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ABSTRACT

The manual provides an overview of Project ForSight, a program to assist parents in teaching their preschool multihandicapped, visually impaired children at home. Chapter 1 presents background information and describes procedures for locating, screening, assessing, and programing the children it serves. Also offered are procedures for replicating the program. Chapter 2 reviews the Project's philosophy of homebased early intervention programs, including strategies for determining an appropriate setting for a program, selecting staff, and developing a framework. Emphasis is placed on the importance of parental involvement with the handicapped child and his educational program. Chapter 3 expands upon the philosophy of how he/she views the role of the professional who works with parents in the home. Appendixes contain instructions for using the Vision-Up Curriculum (which is the basis for assessing and programing children served by the project); instructions for using the Parent Needs Inventory (developed to assess the needs and concerns of parents); a listing of books, articles, and audiovisuals that the project considers useful in working with parents of multihandicapped visually impaired children; and sample forms. (Author/SB)

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project forsight

Early Education Program for Multihandicapped Visually Impaired Children

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During the course of any project many individuals exert great personal and professional efforts. Project ForSight represents the combined efforts of an excellent staff, numerous professionals from other agencies and the parents and children in Austin and the surrounding areas. The project is also indebted to those who have served on the Advisory Council and as fiscal sponsors.

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Thank to all these people is hardly sufficient to express the spirit of camaraderie and dedication evident throughout.

Sincerely,

Lee W. Robinson

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Preface

This manual is designed to serve as an overview of Project ForSight's philosophy and activities involved in serving pre-school multihandicapped visually impaired children. Several approaches are taken in presenting this information.

Chapter One provides information about Project ForSight, including its background, and its procedures for locating, screening, assessing and programming the children it serves. It also includes the project's procedures for replicating the program.

Chapter Two presents detailed information about the Project's philosophy of homebased early intervention programs, including strategies for determining an appropriate setting for a program, selecting staff and developing a framework. Emphasis is placed on the importance of parental involvement with the handicapped child and with his educational program.

Chapter Three expands upon the philosophy of parental involvement. The director and each of the three parent-consultants has described how he or she views the role of the professional who works with parents in the home. Although some points may be duplicated, the three sections provide viewpoints by professionals from slightly different backgrounds and with different perspectives. The articles as a group provide an excellent reinforcement of the areas discussed in Chapter Two.

There are three appendices included in the manual. Appendix

One consists of instructions in using the Vision-Up Curriculum, which is the basis for assessing and programming children served by the project. Appendix Two consists of the instructions for using the Parent Needs Inventory, which was developed to assess the needs and concerns of parents--an important process in the parental involvement philosophy. Appendix Three is a listing of books, articles and audio-visuals that the project considers useful in working with parents of multihandicapped visually impaired children.

TABLE OF CONTENTS

1 Description of Project ForSight

Background 1
Philosophy and Objectives 2
Procedures 6

2 Homebased Early Intervention Programs 23

3 The Role of the Professional in Parent Involvement

Introduction 33
Parental Involvement and Support 34
Parents as Casemanagers 43
Expectations and Intervention Strategies 48

APPENDIXES

1 Vision-Up Curriculum 68
2 Parent Needs Inventory 107
3 Reading and Resources 121

CHAPTER I: DESCRIPTION OF PROJECT FORSIGHT

BACKGROUND

Each state in the country faces different obstacles in meeting the needs of visually handicapped children. What works in one state may not be successful in another state because of the number and location of children being served. In Texas, this is true from region to region, for Texas has many large population centers and many small communities. An itinerant form of service seems the logical way to serve a widely scattered, low density population of visually handicapped children in the state.

In designing a program to meet the needs of Texas's preschool multihandicapped visually impaired children, models from rural states were sought since they have similar population characteristics. It was found, though, that not many programs existed. A search of the Educational Research Information Center (ERIC) showed only one itinerant preschool program. This program, entitled "A Plan for Itinerant Educational Consultant Services for Preschool Visually Handicapped Children" was located in the Allegheny Schools of Pittsburgh, Pennsylvania. It was funded in 1972 by the Department of Health, Education and Welfare.

In 1973, another project, entitled "A Model Project for Identification and Education of Visually Handicapped Children in a Rural State" was funded by the Bureau of Education of the Handicapped and sponsored by the Idaho School for the Deaf and Blind. The experiences

and activities of these two projects provided general guidelines for Project ForSight.

In 1975, the 64th Legislative Session of the Texas State Legislature passed comprehensive legislation affecting the future of services to the visually impaired. Texas House of Representatives Bill No. 1673 greatly expanded the scope of services within the state and created the Governor's Coordinating Office for the Visually Handicapped. With the passage of that legislation, it was possible under state statutes, to provide services to multihandicapped, visually impaired children who function at a pre-school level. The act provided for a wide range of services to visually impaired persons and indicated the need for early identification and educational intervention.

In 1977, the Bureau of Education for the Handicapped funded "A Model Project for Early Intervention and Education for the Unserved, Multihandicapped Visually Impaired Preschool Children in Texas." Project ForSight was sponsored by the Governor's Coordinating Office for the Visually Handicapped and the Education Service Center, Region XIII. In July 1979, sponsorship of Project ForSight was transferred to the Texas School for the Blind.

PHILOSOPHY AND OBJECTIVES

In the normal pattern of education, preschool children live at home and learn the skills that prepare them for public school. But, traditionally, visually impaired children have been removed from

their homes and placed in residential schools to meet their educational needs. However, early institutionalization can create secondary handicaps which severely reduce the child's chances of reaching his maximum potential.

The rationale for Project ForSight is to assist parents in teaching their pre-school handicapped children at home, so the children will have the readiness skills to enter public school at the age of five or six. This strategy helps to eliminate the lack of readiness and the obstacles to a normal lifestyle caused by institutionalization. It also meets the parents' needs by keeping the child in the home and community and provides equal educational opportunities for the child.

The home programming strategy used by Project ForSight considers parents to be the primary agents of instruction. This instruction is based on a developmental model (the Vision-Up Curriculum) and on diagnostic and evaluation services obtained through consultant services and agencies.

The project, insofar as possible, provides equal access to educational and vocational opportunities for multihandicapped, visually impaired children who function at pre-school levels. The access is comparable to that available to their sighted handicapped peers. A primary goal of the project is to prevent or remediate developmental and educational delays imposed by severe visual impairment combined with additional handicaps. In order to meet

this goal, these on-going objectives have been set by the project:

(1) to locate the preschool visually impaired children in the Austin area and in surrounding counties.

(2) to provide, or assist in providing, a medical and educational evaluation for each child and to determine appropriate services.

(3) to provide parent counseling and instruction to assist parents in meeting the needs of their multihandicapped child.

(4) to provide parents and teachers with curriculum guidance including (a) appropriate comprehensive assessment, (b) individual programming related to the assessment results, (c) evaluation of child progress and periodic review of the programming and, (d) parent participation in the planning, programming and evaluation of the child.

As the project is successful in completing these objectives, multihandicapped, visually impaired children should effectively overcome or avoid developmental delays. Thus, they can achieve their highest potential and take full advantages of opportunities available to normally sighted children.

REPLICATION ACTIVITIES

The primary mission of Project ForSight is to provide model services that can be used throughout Texas for education of multihandicapped, visually impaired children. Emphasis of the project

is placed on creating a structured program which not only meets the needs of the target population but which is also adaptable to local service providers across the state.

The model established by this project has several qualities which make it desirable for replication. It provides early childhood education to multihandicapped, visually impaired children. It also provides a flexible curriculum which allows either parents or professionals to serve as the primary agents of instruction. Therefore, services can be provided either in the home or in center-based programs.

Demonstration of the model services takes several forms, depending on the interest of potential replication sites. The levels of dissemination range from awareness of the model to complete implementation of the model. Demonstration occurs in four categories:

(1) Written and graphic descriptions of the specific activities, purposes, costs, etc. are distributed.

(2) Interested parties are invited to visit the project and/or travel with staff members to observe how the activities work.

(3) Documentations of childrens' progress are kept and are available for review.

(4) Training techniques are documented and demonstrated to assist other settings. Potential replication sites invite project staff to assess their programs and to recommend Project ForSight components that may improve

their services. Such assistance consists of in-service training in the use of assessment materials and in the demonstration of curriculum activities with the children.

PROCEDURES

The major components that contribute to Project ForSight's model services include casefinding, screening, assessment, programming, curriculum and parent participation. The first four of these components are discussed in this section; curriculum and parent participation components are discussed in separate chapters.

Casefinding

Handicapped children do not isolate themselves into any geographic setting, economic bracket or other group. In fact, these children are not readily visible in society and may even be hidden by parents who are reluctant or unable to deal with the handicapping conditions.

The casefinding component consists of activities which help identify sources of referrals, make the project's services known to the community and elicit referrals of multihandicapped, visually impaired children. Five basic sources are tapped in casefinding. They include the general public, public and private educational agencies, agencies that serve the needs of the handicapped, medical professionals and public health services.

The two approaches used with each of the groups include increasing general awareness and direct inquiry. Often, the public lacks

information about the handicapped and harbors misconceptions and stereotypes. Therefore, the first approach is to provide awareness of the needs of the handicapped and of the fact that these needs can be met. Emphasis is placed on developing the awareness of groups such as doctors and teachers who come into contact with handicapped children and their families and who might be willing to share information and supplement services already being provided. Although few referrals are derived by increasing public awareness, this method does keep Project ForSight's services in view of the public.

Direct inquiry is a more effective method of obtaining referrals. More referrals come from classroom teachers, relatives and those who deal directly with children on a long-term basis than come from administrators, doctors and clinicians who provide specialized services for a short time period.

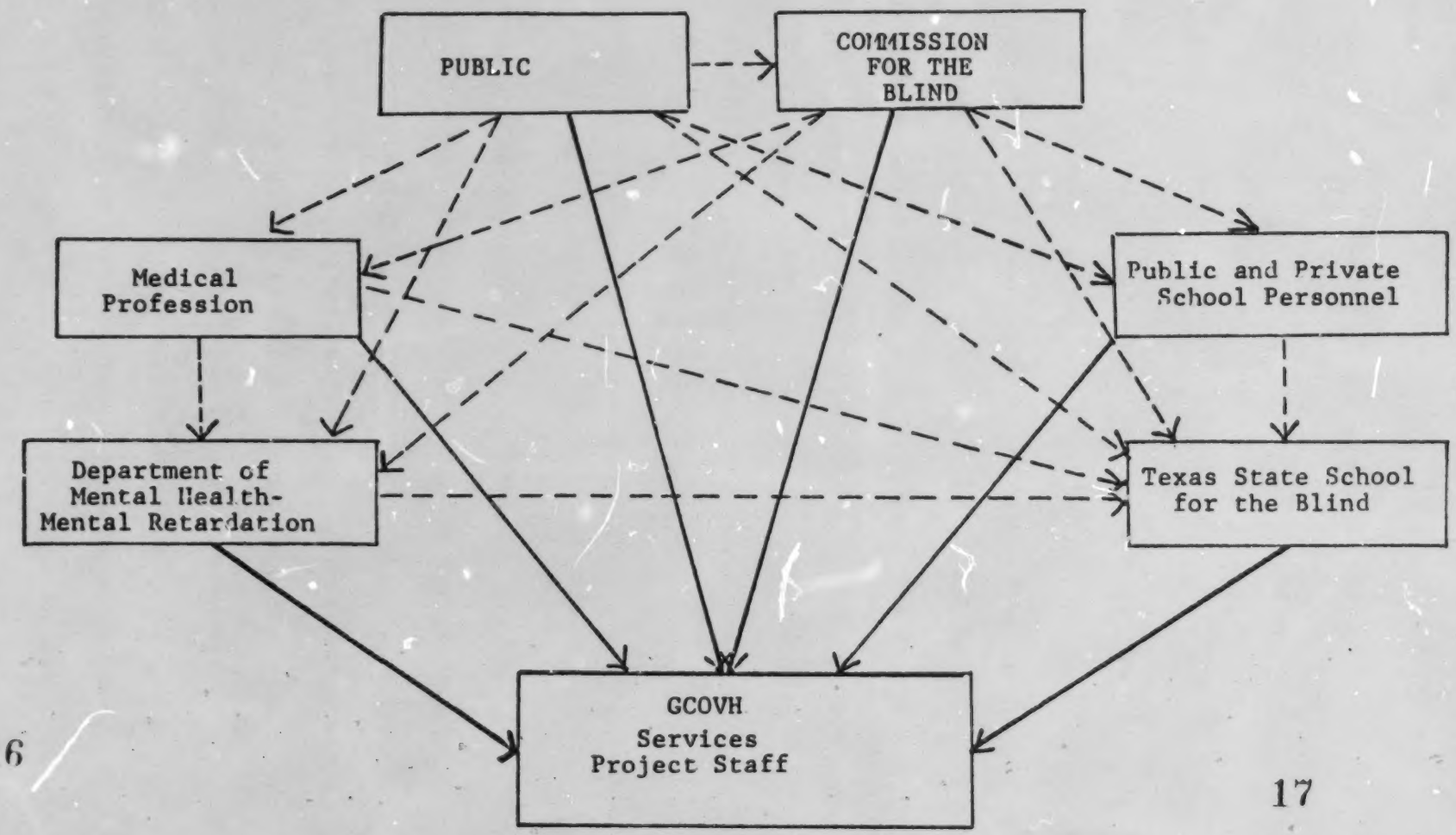
Contact with agencies begins with an appointment with the agency director or supervisory personnel to explain our services, gain referrals and explore ways in which we may be of service to the agency. During the initial visit we make the point that we are ready and willing to assist in any way possible, and we leave a summary sheet describing the project and how to contact us. Special contact information is given to physicians, optometrists, and agencies serving special education populations.

Upon receiving a referral, a staff member completes a referral

CASEFINDING

FLOW CHART

Methods of Referring Multihandicapped Visually Impaired Children for Service



card with the name, address and birthdate of the child; the name of the person making the referral; current placement of the child and specific reasons for referral. A follow-up visit is made to the person making the referral to gain as much information as possible.

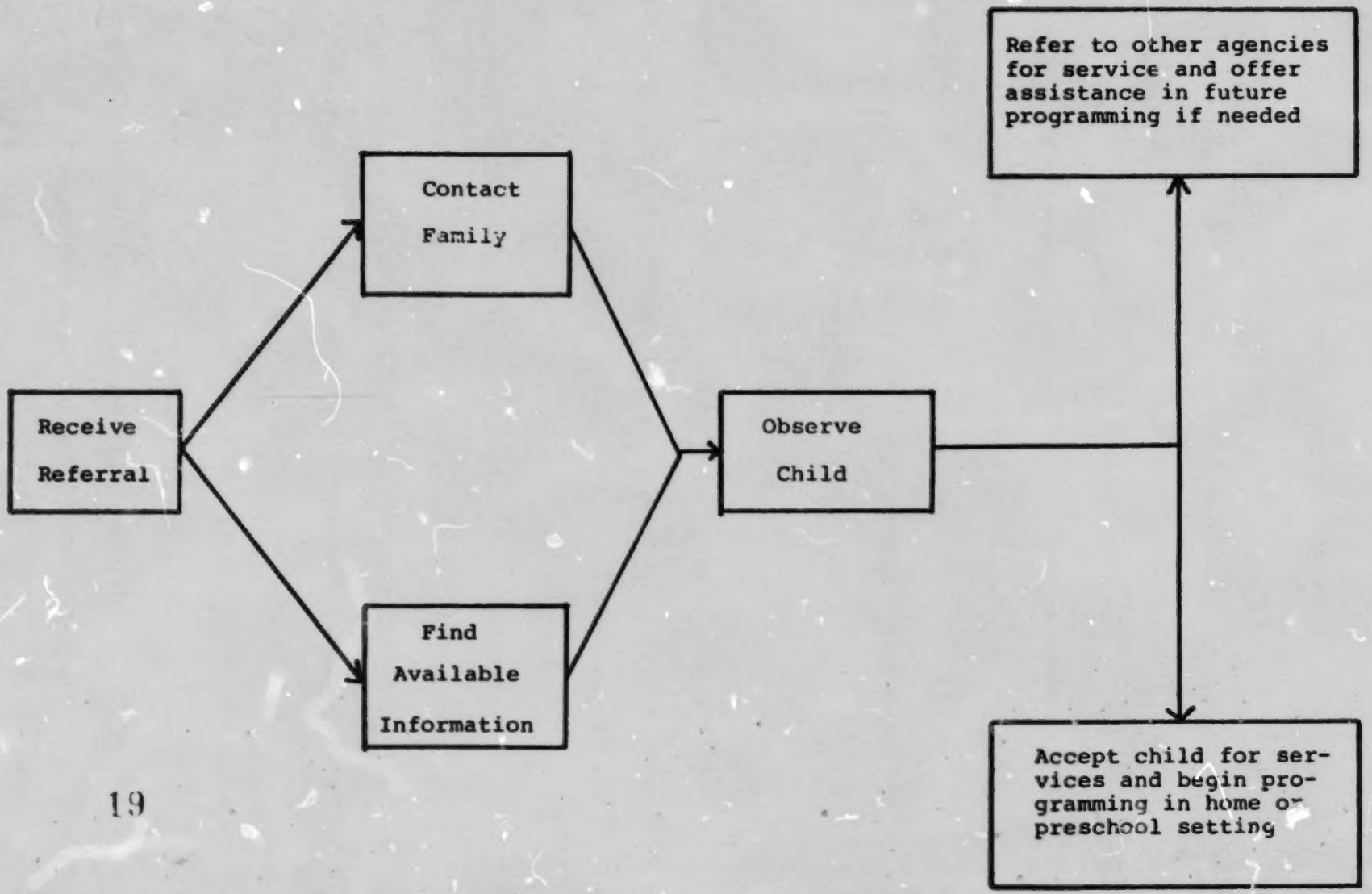
Personal contact is made with the family to explain Project ForSight's services, to observe the family setting, and to obtain release forms for diagnostic and evaluation reports from agencies that have served the child. In many cases, the referring agent accompanies the Project ForSight staff member to the family to introduce project services.

If the child is handicapped in any way, he is reported to the local and regional Child Find-Child Serve Projects to assure that services will be available if the child does not meet the delimitations of this project.

Screening

After a child has been referred to the project, a parent consultant screens the child to determine if he has a vision problem serious enough to qualify for the program. The screening process usually takes about a month to complete, but may take longer in the case of a severely handicapped child. However, screening is completed as quickly as possible and the child is either accepted or placed into a more appropriate program. Delay of this process causes lack of valuable education time for the child and frustrates the parents. On the other hand, the parent consultant must have

SCREENING PROCEDURES


Refer to other agencies for service and offer assistance in future programming if needed
Contact Family
Receive Referral
Observe Child
Find Available Information
Accept child for services and begin programming in home or preschool setting

sufficient time to gather the necessary information for without sufficient data she cannot determine the best educational program for the child.

Information about the child's vision problem is obtained from his doctor and any agencies which have served the family. This information includes the nature of the vision problem (from a current eye report, if one is available), age, educational programs in which the child is enrolled, etc. The information gathering is an ongoing process which continues as new information is made available.

The screening criteria established by the project are designed to include rather than exclude children from the project. Multi-handicapped, visually impaired children are a low incident population often excluded from some services because of their visual impairment, even when it is far from the most significant handicap. Many times the visual impairment is difficult to detect because of severe involvement of other handicaps; therefore, if there is any question, the project includes the children in the program until it can be demonstrated that the child does not have a visual handicap. This is preferable to accepting a child only when the visual handicap can be clinically proven. The criteria for screening children for services are as follows:

(1) The child must be 0-8 years old or developmentally equivalent to this age. Children who are chronologically older than

eight, yet have not reached the minimal age for consideration as vocational rehabilitation clients may find appropriate services through the project.

(2) The child must be visually impaired. In general, a visual acuity of 20/70 in the better eye after best correction, or a field of vision not greater than 20° is the criterion for service. A statement from an eye specialist verifies the visual condition. There are no standardized procedures which reveal accurate visual acuities for multihandicapped, visually impaired or very young children. Therefore, observation or verification by project staff may temporarily qualify the child for services pending further observation or verification of the visual problem by an eye specialist.

(3) The child must have at least one additional handicap which may include developmental delay. The additional handicap may be verified through use of the Vision-Up assessment tool or by statements and assessments from other professionals. Because of the lack of standard measures and proven instruments, all assessments are verified through staff observations.

In general, the following guidelines are used. Visually impaired children with additional impairments who are not currently receiving services receive medical diagnostic evaluation, educational programming and evaluation, parent counseling and family social services. If adequate medical diagnosis and evaluation have

taken place, only educational evaluation and programming, parent counseling, and so forth are provided by the project. If present services are adequate, project services are not extended.

Children diagnosed as deaf-blind are not served by the project because of special funding and program arrangements for them. These children are referred to programs for deaf-blind children sponsored by the Bureau of Education for the Handicapped and implemented through regional and local service agencies.

Clients served by the project reside in the Austin metropolitan area or the six surrounding counties. Exceptions are made when the number of children in one setting justifies the amount of time and travel, or a child is brought to a site within the metropolitan area on a regular basis or when staff members make trips outside the Austin area for dissemination, replication or other activities.

If screening determines that the child does not qualify for services, the parent consultant locates an appropriate agency to work with the child, refers the child and his family to that agency and assists in future programming for the child if it is needed. In these cases, the parent consultant follows up at a later date to verify that the child is receiving the services he needs. If he is, the case is dropped.

It is important for the parent consultant to place these children in the program which will most benefit the child, because not only is it best for the child, but it demonstrates the genuine interest the project has for the child. This encourages those who

made the original referral to continue making referrals and improves the public image of the project.

An annual assessment is made of all children in the project to determine if the screening procedures are adequate. This helps to determine if the data gathered provide for appropriate placement, or if the screening is being delayed by gathering excess information.

Assessing

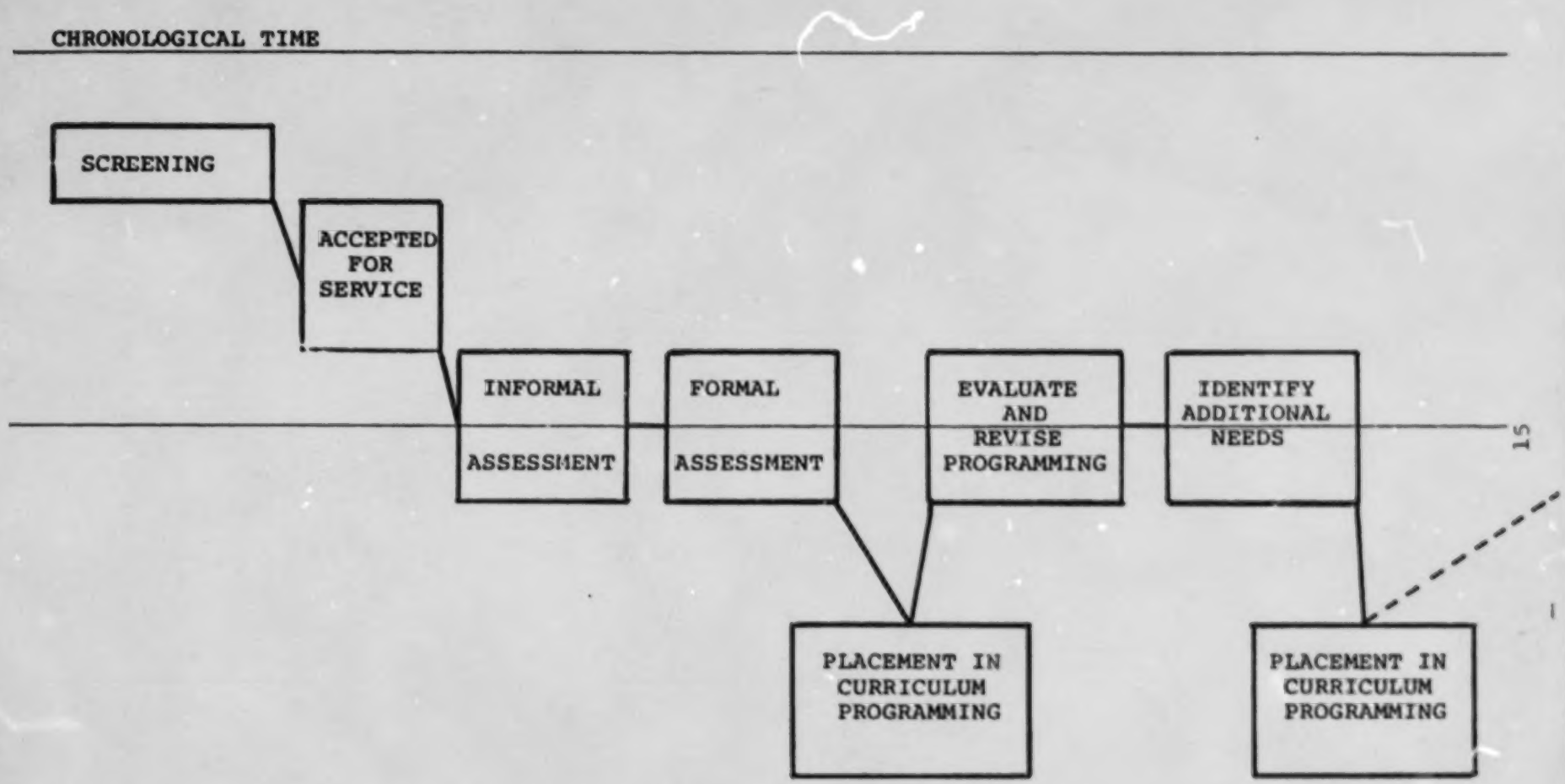
Before the parent consultant can design an educational program for the child, she must first determine the level at which the child is functioning. The assessment procedures provide this information quickly and accurately.

The assessment process consists of activities which determine the factors affecting the child and his family. Such factors range from the performance level of the child to the attitudes and socio-economic factors prevalent in the family.

Assessing Children. A period of informal assessment begins with the initial visit and continues until the formal assessment begins. During the informal assessment, the parent consultant develops a rapport with the family and begins assessing the parent's attitudes towards the handicapped child (e.g. is the attitude a healthy one? Does the child have a good self-image? etc.)

During the informal assessment, short-term educational goals are formulated as the parents express their needs. These needs

ASSESSMENT AND PROGRAMMING



usually involve some kind of self-help skills (toilet training, feeding, language) which the child has been slow in learning. When such needs are identified, the parent-consultant immediately begins to design a program to meet those needs. This gives the parents immediate encouragement and may make them more willing to become active participants in the formal assessment, the project and their child's education.

Once rapport has been established with the family, the parent consultant uses the formal assessment to identify the particular educational needs of the child. The formal assessment consists of an assessment of the general performance level and assessment in areas which deviate from normal expectations of development. The general assessment is performed with the Vision-Up Curriculum assessment which assesses intellectual, language, physical, social-personal, fine motor and self-help skills. Standard tests such as the Barraga Visual Efficiency Scale, Slosson Intelligence Tests, or the Maxfield-Buchholz Scale of Social Maturity for Use with Preschool Blind Children might be used to supplement the Vision-Up Curriculum.

If delay or unusual development is indicated in any area, the parent consultant assists the parent in obtaining clinical assessments. If the problem appears in the area of physical development, a physical therapist is contacted and arrangements are made for further evaluation. Likewise, if the problem appears in language

development or social-personal development, a speech-language specialist or psychologist is contacted. A medical doctor is contacted if unusual symptoms appear.

The parent attends the clinician's evaluation in order to obtain as much information as possible about the condition. Should the clinician find deficits or unusual development, the parent consultant shows him/her the Vision-Up Assessment and activities which have been selected to move the child along a normal pattern of development. The clinician sanctions the activities of the curriculum and/or recommends alternate programs for correction of the problem. A decision is made regarding who will carry out the activities. The clinician may supervise the parent consultant in these activities or a schedule of treatment may be arranged at a clinical setting. Follow-up activities with the clinicians are scheduled according to their recommendations.

Assessing Parents. The assessment of parents helps determine their ability to deal with the problems presented by the presence of a handicapped child in the family. The Parent Needs Inventory is used to assess the areas of emotional needs, knowledge of child development and knowledge of available resources.

The design of the Vision-Up materials and the Parent Needs Inventory provide for ongoing assessment each time new programming is selected. However, at least once a year, a complete reassessment takes place for each child and family receiving services from

the project. This provides assessment of the child's progress and measures the effectiveness of the teacher in parent instruction.

Programming

When the assessments have been completed an Individual Education Program (IEP) is prepared for the child and discussed with the family. The plan includes a summary of the results of the comprehensive assessments, pertinent medical and diagnostic information regarding the handicap, appropriate identification information, a list of service providers and long-range developmental goals. Much of the IEP is based on the programming activities established in the Vision-Up Curriculum.

If the parents agree with the goals and objectives and approve of the service providers and timeline, they sign the IEP. A review date is established at the time the IEP is signed by the parents.

The programming activities which render services to children and their families can be accomplished in three modes--home services, agency services, and consultant services. The primary difference between the three modes is the amount of involvement by Project ForSight staff.

Home Services. The parent consultant makes a weekly home visit of one to two hours. For the convenience of the family, visits are scheduled in advance and confirmed by telephone. When possible, the parents and parent consultant establish a regular

schedule of meetings.

Parents have input and final say concerning the educational goals. For example, even though Fine Motor development may appear to be the area most in need of programming, it may be better to emphasize Self-Help skills or other areas that are of concern to the parents. This is because motivation and success are especially important to parents in the early stages of programming. As the child progresses, the parent will see the need to stress the areas indicated by the assessment. Should the parents select goals which are unrealistic, the parent consultant explains why other goals are more appropriate. Use of the Vision-Up Profile Charts minimizes the conflicts between parents' and parent consultants' goals and enhances the explanation of the order of the tasks to be completed.

In the next step, the parent consultant explains the programming activities that have been selected. She demonstrates the activity and asks the parents to carry out the same activity with the child. Having the parents perform the activity in the presence of the parent consultant assures that they have the ability and understanding to implement the activities.

The next step is to establish criteria for success and to establish a monitoring system to give feedback on the effectiveness of the programs. In general, the criteria are based on the child's ability to complete a task. For example, if the child is able to

complete a particular task 80% of the time, it can be assumed that he can do the task. The criteria for success vary with each child and with each task. For example, a severely handicapped child with seizures may require a higher ratio of success to failure than children who are less handicapped. If after a reasonable period of time and a consistent effort, the child has not completed the task, it may be necessary to analyze the task to make smaller increments or to check for pre-requisite skills that will make the task easier to complete. If the child has extreme difficulty in completing tasks, further evaluation is obtained from an appropriate clinician.

A routine of visits is established to review to procedures for assessing activities, selecting new goals, demonstrating new activities, determining the parents' abilities to carry out the activities and establishing new criteria for completion of the tasks. The parent consultant identifies needs which have become apparent since the last visit and, if necessary, revises the program. This process of treatment--evaluation--revision is repeated until a decision is made to stop or until the program is completed.

Agency Services. Services offered by Project ForSight to programs that serve multihandicapped, visually impaired children are similar to those offered in home services. However, since professional staff are available at those centers, less involvement of Project ForSight staff is necessary. Programs are visited

on a regular basis; the amount of time is agreed upon by the parent consultant and the teacher at the center.

The Vision-Up Profile Sheet helps identify short-term educational goals, provides the basis for discussion between the teacher and parent consultant, minimizes the amount of discrepancy in goal selection and maximizes the ability of the parent consultant to justify the selection of specific educational objectives. The classroom teacher is responsible for establishing the criteria of success and for monitoring the effectiveness of the programming and program changes.

The parent consultant observes the teacher's interactions with the visually impaired child and offer suggestions concerning the programming. She demonstrates or assists in adapting the activities to the needs of multihandicapped, visually impaired children. This is especially true with regard to making the regular classroom teacher feel comfortable working with visually handicapped children, or in providing information outside the teacher's expertise (e.g. providing language information to a physical therapist).

Consultant Services. Children may be served in a more indirect way as project staff are invited to observe and make suggestions at agencies attended by multihandicapped, visually impaired children. The nature of the consultant services depends on the type of services provided by the agencies. Requested

workshops include Child Development, Community Resources, Parent Assessment, Vision Screening and Stimulation and Child Assessment.

CHAPTER II: HOMEBASED EARLY INTERVENTION PROGRAMS

Project ForSight philosophy is based on a home-based early intervention program emphasizing parent involvement. This chapter provides an overview of the advantages and trends of early intervention, a description of possible settings for early intervention programs and a brief discussion of parent needs and involvement.

What is the purpose of early intervention?

Early intervention provides educational opportunities for the child to remediate developmental difficulties as early as possible. The results of many studies show that the best time to work with handicapped children is before they become school age and are already delayed. An HEW study reports that by the time the child reaches eight years of age, he has obtained 80% of his total adult intellectual capacity. Therefore, reports Roos (1974) "the best time to attack a child's mental or emotional handicap appears to be the period from birth through early childhood." Ellis (1977) confirms this when he states "It may be that in order to avoid a "wash out" of early gains and to prevent disadvantages or exceptionality from having a lasting effect, early education programs should begin prior to age three, perhaps as early as birth". Kirk (1969) states that "training infants at the preschool level accelerates the rate of mental and social development while no intervention at that age level tends to allow

the rate of mental and social development to slow."

What are some advantages of early intervention?

Early intervention may do more than remediate developmental delays; it may reduce or even eliminate long term care that is often necessary if the child's handicaps are not dealt with an early age. Weikart (1971) suggests that "early help may make it possible for that child to move into a regular education program earlier than the child who receives no early assistance."

Not only does early intervention provide better educational opportunities for the child, it makes special education programs more cost-effective. Compared to the cost of educational and social problems that may be prevented by early treatment, early intervention is relatively inexpensive.

What are some of the legal trends concerning early intervention?

Trends in the areas of law, education, psychology, and society are indicating that early intervention and childhood education are coming to the forefront of child development philosophy. In the area of legal trends, the 1974 National Governor's Conference, the National Education Association and others have publicly endorsed early education programs for the handicapped. Establishment of the Bureau of Education for the Handicapped and the passage of legislation such as P.L. 91-230 and P.L. 94-142 have made early education for the handicapped fiscally possible (Ellis and Cross, 1977).

The passage of P.L. 91-230 (Title VI) "The Elementary and Secondary Education Act Amendments" in 1974 made it possible for states to receive grant assistance for education of handicapped children and authorized funds to public and private non-profit agencies for the purpose of establishing and operating model early education projects for the handicapped. In 1975, it was amended by P.L. 94-142 "Education for all Handicapped Children Acts" to ensure that all handicapped children have free public education with related services to meet their "unique" needs, to ensure that the rights of parents and children are protected, to assist state and local agencies in assessing handicapped children, and ensuring the effectiveness of efforts to educate them.

What other trends concern early intervention?

In the area of education, attitudes toward services for the handicapped are changing. As school programs comply with mandates for the education of the handicapped, more early intervention programs are being developed and teaching techniques are being improved. Whereas educators have traditionally taken a "forget and hide" approach towards the handicapped, they are now utilizing an "identify and help" approach.

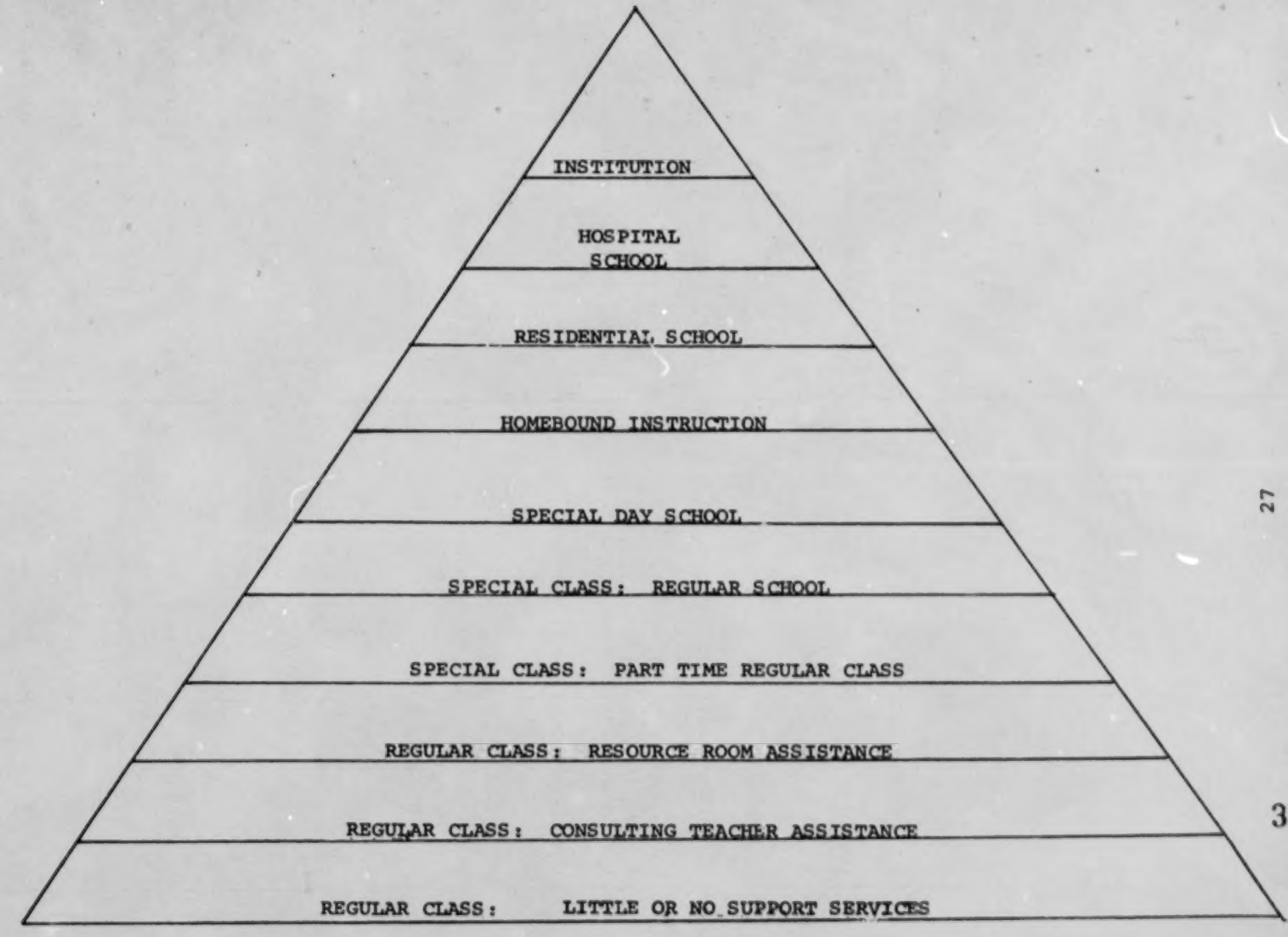
In developing new techniques and approaches, three aspects of child development are considered in early intervention programs. The first of these is the fact that children develop their cognitive and sensory skills at a young age. Second, is the fact that

young children are not passive to their environments, but are motivated intuitively to explore their surroundings. Third, both nature (heredity) and nuture (environment) play a role in child development. Environment is a factor that can be manipulated and thus, there is a trend for the role of the educator to be a provider of opportunities for self-initiated explorations by the child.

There are several other trends in society that are making intervention a prominent national issue. Parents of handicapped children are forming organizations such as the National Association for Parents of the Visually Impaired to promote understanding, establish clearinghouses, and foster communications among programs that serve the handicapped. The "women's rights" movement and the rise in the number of women entering the work force have increased the need for child care facilities. Likewise, the fact that the medical field is now able to save premature infants who have a greater risk of central nervous system damage, brain damage and motor and language development difficulties, increases the need for early intervention programs for the handicapped.

What settings are available for early intervention programs?

Figure one illustrates the continuum of instructional settings available to the multihandicapped. The most restrictive programs are listed at the upper levels; the least restrictive are listed at the bottom. Because of the severity of their handicaps, severely multihandicapped, visually impaired children are


INSTITUTION
HOSPITAL SCHOOL
RESIDENTIAL SCHOOL
HOMEBOUND INSTRUCTION
SPECIAL DAY SCHOOL
SPECIAL CLASS: REGULAR SCHOOL
SPECIAL CLASS: PART TIME REGULAR CLASS
REGULAR CLASS: RESOURCE ROOM ASSISTANCE
REGULAR CLASS: CONSULTING TEACHER ASSISTANCE
REGULAR CLASS: LITTLE OR NO SUPPORT SERVICES

usually placed in the programs at the upper, or more restrictive levels. However, the majority of these children should be able to receive appropriate services within the middle range of the continuum--homebound instruction, special day schools, center-based programs or special classes within regular schools.

What services do these settings provide?

Of the alternatives used for early intervention programs, the most restrictive are state or private residential institutions and hospital schools. These settings provide year around care for profoundly handicapped children whose needs cannot be met by their families or by existing local programs.

The next level on the continuum is a residential school such as a state school for the blind. Such programs usually provide training in self-care, daily living skills and pre-vocational and minimal academic skills. Although programs at these three levels provide services to multihandicapped visually impaired children, almost none of them provide services to pre-school children.

Local educational programs, however, can provide services that are appropriate to pre-school children. Local education programs are generally either center-based or home-based or a combination of both. In a center-based program, a handicapped child is brought to a classroom for several hours of education and therapy, either by a classroom teacher or itinerant therapists. In a home-based program, the professional visits the family, in order to work with the child and family in the home environment.

What is a "home-based" program?

Although most center-based programs offer some services to the home, the extent of the services varies according to the philosophy of the program. Some programs consider themselves home-based because they allow parents to work with the teacher in the classroom, to serve on advisory boards, to plan activities for the child or to attend parent training sessions.

However, home-based program is usually defined as a program where the primary education takes place in the home. Many programs in which the teacher visits the home several times a year are considered home-based. Although this frequency of visits allows parents some input into the child's program, it does not provide opportunity for the parents to become fully involved in the child's daily educational activities.

What advantages do home-based programs offer?

The ideal home-based program is one in which the teacher or professional visits the home on a regular schedule, not only to teach the child, but to involve the parents in the entire educational process. By including the parents in the assessment and by demonstrating instructional activities for the parents to carry out with the child, the professional helps the parents become the child's primary instructor. By showing parents how to use resources and by showing parents how to become efficient case managers, the professionals help the parents to assume full responsibility for their child's program.

Robinson (1979) cites several advantages to home-based programs. These include:

1. Parents have a vested interest in the child. They are perhaps the only persons who do things for a child for totally unselfish reasons. They are the ones who don't count the cost before deciding to sacrifice time and energy for their child.

2. The home provides the natural setting for learning the things that the child is ready to learn. A daily routine of activities that is meaningful in the time and cultural setting where the child lives is the real life experience education always strives to duplicate. The home setting is the best on-the-job training for children.

3. Home-based models do not drain as much of the family's energy. More time and energy is available when transportation time is minimized, nap times are not interrupted, and the child has familiar surroundings and objects to experiment with. The younger the child, the more applicable these factors become.

4. Home-based programming tends to elevate or preserve self-esteem for the parents. They are not in the servant role waiting to see what the professionals want them to do next. They are not out in an alien environment doing battle for their child by trying to understand what is happening. In other words, professionals are lending dignity to the parent by going to them and offering services rather than expecting parents to ask or demand.

What are some of the advantages of center-based programs?

There are, of course, advantages to center-based programs. Special equipment and facilities can be provided and the time of professionals can be used more efficiently. Often, parents feel inadequate to handle the problems of their handicapped child and prefer center-based programs. And, center-based programs provide social experiences for children that may not be available in the

home. Certainly there is a place for both types of programs in the child's educational process.

What is parent involvement?

Parent involvement is rapidly becoming recognized as an important component in the education of handicapped children, especially as schools try to meet the mandate of Public Law 94-142. Unfortunately, too many programs view parent involvement only as the parent's interaction in the development of the child's I.E.P. The concept of parent involvement, however, should be extended to meet the needs of the parents as well as those of the child.

What are some of the needs of parents?

The needs of the parents multi-faceted. For example, parents of handicapped children need to have a knowledge of child development upon which to base their expectations for the child; they need to be able to locate and utilize community resources such as counseling and recreational services.

Not all of the parents' needs, however, involve finding help for the child. Parents of handicapped children experience a grieving process that is often difficult to overcome. They must struggle with fears and anxieties about their own lives. They must decide what role the handicapped child will play in their lives and how the child's needs will affect their future. They must deal with the effects of a handicapped child on their marital and extended-family relationships. And they must constantly choose where their energies and commitments will be concentrated.

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CHAPTER III: THE ROLE OF THE PROFESSIONAL IN PARENT INVOLVEMENT

The philosophy of parent involvement is concerned with more than teaching parents to work with their handicapped child. Parents have needs as individuals in addition to their needs as parents. The professional can help meet those needs by serving as a friend and advocate, by working with parents to identify and prioritize their needs and by helping the parents fulfill their potentials as parents, citizens, and especially as individuals.

Each professional brings a different set of skills, experiences and outlooks into a relationship with parents. And, professionals have different views of their roles as parent consultants. This chapter consists of three papers written by the professional staff members at Project ForSight. Each paper discusses the role of the professional in a parent-professional relationship, yet each approaches the role from a slightly different perspective. Lee Robinson, the director, discusses specific needs of parents that professionals should consider. In Section 2, Jeri Cotton presents her ideas of working with parents to help them become better case managers for their child. In Section 3, Diane Nousanen and Steve DeRosa discuss the expectations parents and professionals have of each other, and methods for successful intervention.

Parental Involvement and Parental Support

Lee W. Robinson

Project ForSight is a home-based program because the home and family setting provide the best environment for the development of the pre-school child. Parents have many competencies that are often overlooked, such as an unmatched love and concern for their child and a knowledge of his abilities derived from living with him everyday. Parents are definitely capable of carrying-out programming, especially when they are shown how to work with their handicapped child. Parents of handicapped children have a variety of emotional experiences and need to be given reinforcement and encouragement. It is important to help parents work through the early period of shock and grief, the search for the cause of the handicap, the period of blame and their concern for the future. We do everything possible to support the home and family and to make the parent feel confident and capable of raising the handicapped child with joy and excitement.

There are many skills necessary for successful educational programming in the home setting. The teacher, parent consultant, social worker, or nurse who visits homes needs to have a variety of skills, including knowledge of counseling techniques, skill in questioning, the ability to perceive social interaction, and the ability to describe observations accurately. Many of these skills are taught in academic courses; however, many of the skills can

only be acquired through practical experience when personal skills are natural and unaffected.

The cluster of skills most needed is the ability to perceive and give considerate assistance to the needs of parents. Too often when outside assistance is brought into the home, the needs of the service agency or personal needs of the instructor interfere with assisting the parents. This results in continuous resistance to the teacher's efforts and builds a wall between the agency, teacher, and the parents.

The needs of the entire family must play a part in determination of the type and amount of assistance needed by the family. The following statements are some of the considerations that should be made:

Values of the family. Many times home visitors and families come from vastly different social strata and it is not unusual for the visitor to feel uneasy with families from a different social class. It is important for the home visitor to recognize the difference between harmful parenting and untraditional, but harmless parent practices. For example, there is a difference between spanking and child abuse. This difference is not only in the degree of physical force applied, but also in the motives and control shown by the parents. The same dimensions may be applied to nutrition, cleanliness, and dress. While home visitors have every right to protect a child from physical and mental abuse, they have

no right to demand social conformance by forcing parents to comply to their standards in the prescribed programming or to withhold services because of lack of compliance.

Time. A second consideration is the amount of time available to the family for carrying out programming. This can be influenced by many factors, such as the number and ages of other children in the family, whether the mother is employed, transportation problems of the family, and so forth. The implications of time can be far reaching and not readily apparent to the home visitor who does not know the family's daily routine. Many times the home visitor is critical of a mother for not carrying out a program according to instructions. However, if the mother has sick children, activities outside the home, or any crisis situations which upset the normal home routine, she can hardly be expected to drop all other important matters in favor of this program.

Another important consideration is finding a convenient time for the family which is not embarassing to them. For example, inconvenient times include before the living room is straightened up, wash day, the day guests are expected, or while someone in the family is sleeping. It is important not to "drop in" and expect to take up family time. If there are other children in the home, it may be difficult for the mother to discuss programming for any uninterrupted length of time. It may be helpful to bring toys or games which will occupy the children. It will also be helpful to

keep visits short and to the point, unless parents indicate otherwise. For example, a mother may be more than happy for a few minutes to talk to someone other than the children. On occasion it may be most helpful simply to "babysit" for awhile. Again, the teacher must call on her perceptive skills to determine what is needed and what will work to the best interests of the child in a situation.

Making time for programming is also determined by the parent's perception of the importance of the task; if the parent sees the task as genuinely important, time will be made available. If the parents offer excuses that they did not have time, the teacher should re-examine the task in terms of its meaningfulness to parents.

Parent Interest. Parent interest is a crucial element for successful home visits. Many times a professional accuses parents of a lack of interest without considering the possibility that he may be responsible for that lack of interest. Often, the educational, social, or health background of home visitors predisposes them to work in some areas more than others. For example, a teacher with a background in language may be more interested in promoting language growth in children. The same phenomenon occurs in other areas. Sometimes home visitors forget that parents, as well as other professionals, do not share their interests. The result is that as soon as the pressure to perform is removed, parents ease up on the program. Especially in home-based programs, relatively

little consistent reinforcement to parents can occur. Consequently, the professional often feels frustration because progress does not meet their expectations.

Parents' interests have to be taken into account in order to eliminate this frustration for the professional, to meet parents' needs more effectively, and to gain greater child progress. In other words, if the child is lagging in Fine Motor Skills and Self-Help Skills, and the parent is primarily interested in Self-Help Skills, it is wise to assist the parent in programming Self-Help Skills. If the parents are successful with the programming suggested by the home visitor, they develop confidence in the program and a closer personal relationship with the home visitor. This puts the home visitor in a stronger position at a later time to offer suggestions in areas of lesser interest to parents.

Services to Parents. Any effective program for the handicapped must consider the parents' feelings. Three considerations can help parents eliminate the frustrations they feel as they deal with daily problems of living with their handicapped child. First, parents need to feel that they have some control over what happens to their child and in deciding what is best for him. Second, parents need to accept the child, both as he is at the present time and with realistic expectations for his future. Third, the parents need a knowledge of resources and alternatives to meet their needs in raising a handicapped child. Project ForSight

tries to meet these three needs by the services provided to parents.

Because of the complicated nature of working with multiply handicapped children, parents often feel inadequate to deal with their child. Parent consultants strive to improve the parents' ability to deal with their child by enhancing the parents' self concept. The most effective way of doing this is by showing the parents how to work with their child, for when parents are convinced that they are capable of providing direct instruction to the child, their self-concept is immeasurably improved.

Parent-consultants spend much time instructing parents in the principles of teaching skills. Such instruction generally comes in a practical setting with hands-on experience as the principles are explained. As the parents see a need for a particular behavior, such principles are explained in terms of the parents' observations.

Often times specific technology instructions are given to parents on an informal basis. Technologies such as behavior modification, modeling, role play, etc., are explained in relation to specific activities in the Vision-Up Curriculum. When significant numbers of parents are in need of similar teaching methods and skills, parent group activities are scheduled and the consultants present the information in workshop activities.

Another way to improve the parents self-concept is to encourage

parents to be more assertive in making their needs known to the professional community. When parents are encouraged to ask questions and not to feel intimidated by professionals, they gain an understanding of the child's condition and are better able to follow clinical recommendations.

During meeting with clinicians or professionals, the parent-consultant may serve as an advocate for the parent by asking questions which the parent does not ask or by rephrasing answers given by the professional, to be sure the parent understands what is said. Care is taken in such situations not to usurp the parents' role in the parent-clinician relationship. Often consultants find themselves searching for additional information after the meeting has taken place. This support role of parent-consultants alleviates many of the self-concept problems and heightens communication between parents and clinicians.

Improved self-concept will also come as the parents feel they have more control over what happens to them. The Vision-Up Curriculum is designed to allow the parents input into deciding what is best for the child. The parents are given a graphic representation of the child's areas of abilities and limitations (in the form of the Profile Chart) and can better decide which areas need work.

Emotional support is critical to the family. This is especially true in the case of the one-parent family, but even in two-parent

families, the mother is often required to attend important medical and educational meetings without the attendance and support of other family members. One of the roles of the parent-consultants is to be a friend and advocate in such situations. Occasionally it is helpful to the family to have an additional pair of hands to manage the other children or to assist in the mechanics of getting to and from an appointment. Project ForSight offers respite care; a mother can make an appointment to leave her child with a parent-consultant when she has functions to attend or when she simply needs a break from routine child care.

Parent Reinforcement. Parents of handicapped children may not be motivated to provide the extra effort to see that their child progresses. There are many things which discourage their attempts to try new programs. Just as some teachers have difficulty working with handicapped children, parents may have difficulty wanting to carry out various tasks. Motivation to carry out programs comes in the form of many reinforcers. Many times the most motivating reinforcement is praise and a feeling of success. Therefore, it is important that any program, insofar as possible, ensure that the parent will be successful, and that the parent is made aware of the success. Home visitors should remember that progress is not as evident to those who live with the child as it is to those who see the child on a periodic basis, because change takes place slowly, not dramatically.

Comparison with other parents or children is not a good practice. Establishing a starting point, and comparing the child to this baseline is the most appropriate type of progress to show the parents. Point out logical reasons when progress is slow without giving parents an excuse to discontinue programming. The most effective reinforcement will be visible progress of the child and feelings of selfworth in the parent. Anything the home visitor can do to promote these will assure greater participation by the parent.

Parents as Case Managers

by:
Jeri Cotton

In working with the parents of blind multihandicapped infants, one would do well to consider these words of one of the leaders in our field, Berthold Lowenfeld: "We are often inclined to take over the role of the parents rather than assisting them in becoming themselves more capable of coping with problems confronting them." As the first of the many teachers to come into a family, our most beneficial goal would be training parents to become efficient case-manager for their child. As parents of newborn handicapped children are firstly in shock and secondly entering a "new world," it is necessary for them to be almost totally dependent in matters concerning their handicapped child. Therefore, attaining our stated goal becomes a process much like that of raising a child. We start with parents who are totally dependent on us, we nurture them and develop their self concept in positive ways, we teach them slowly and patiently and all this time we are gradually weaning them so that one day they can take care of their needs independently.

The first step in this process is supportive counseling. This is the step that is skipped by many programs that deal only with the child, however, it is in many ways the most important step in our process. This is the time when we build rapport with our parents and encourage them to explore and accept their feelings

about this disastrous change in their lives. This is the time when we can influence infant-parent bonding, can prevent the "poor blind child" syndrome and can assure that a healthy family unit remains a healthy family unit. Though the need for supportive counseling will diminish as we proceed through the steps toward our goal, it is vital that it continue to be available as needed and that it remain in our general approach to these families.

Next we become suppliers of information. We inform our parents of magazines such as Exceptional Parent. We lead them to parent organizations and take them on visits to the schools which their child might attend in later years. We discuss services available in our community such as SSI or genetic counseling or recreation for special populations. We lend books like Can't Your Child See or Get a Wiggle On. We introduce the talking book program-yes, even infants can enjoy listening to stories and cause and effect can be learned through manipulating the remote control unit. We lend lights and toys to help the parents identify what works best to stimulate their baby's visual and intellectual development.

From information supplying, we gradually change our approach to that of teaching parents where to look for information themselves. This can be done, now, because we have familiarized them with the basic social service agencies in the community. We begin by modeling this skill.

As we supply our parents with information, we begin to relate to them the way in which we found the specific service or book or whatever. This explanation might sound something like this, "I called the Department of Human Resources main phone number and described what I needed. They gave me the number of one of their offices which I called. They referred me to another DHR office who said that they thought that Mental Health/Mental Retardation provided that service. I called MHMR main office where I was told that the service I was looking for was not provided by MHMR, but that they would connect me with someone who might be able to help me find the correct agency. This person gave me a few possible leads and one of them was correct. The process took an hour on the phone and many calls but I did find the service and I asked each agency to send me information on the services it provided while I was talking to them." It is imperative to be honest about the amount of time and effort it takes to find services. If it is made to sound too easy, it will lead to frustration when parents try to find services on their own.

Continuing along our path, we get into teaching parents how to efficiently use the services they locate. This again starts with modeling and assertiveness training. We accompany parents to the located service (agency, doctor's visit, etc.) and model for them how to interact and question until sufficient understanding is attained. Little by little, we step back and let the

parent interact with only our presence for support.

From this point, the parents are ready to act more and more independently of us in the area of case management. The security of having a teacher to fall back on when necessary makes this independence more comfortable.

It must be stated that this process was written in a structured, systematic manner strictly for the purpose of assuring that the reader could clearly follow the steps to the goal. Conversely in our interactions with parents, we avoid structure and formality.

Working as a parent-teacher team cannot begin until a sincere and caring relationship has been established. We essentially become a member of each of the families with whom we work. We start by sharing grief and, in turn, are allowed to share jubilation when progress is made. Only when we let it be known that we don't automatically know what to do in every situation, are parents comfortable enough to try things on their own. Only when we relieve parents when their children are hospitalized, attend parties or similarly show that we are truly involved can we afford to good-naturedly scold a parent for being overprotective.

We truly enjoy working with our parents and this certainly leads them to enjoy working with their child.

In short, we feel the way that Eileen Scott did when she said, "...we are convinced the best service which we can provide for a visually impaired child is to help his parents develop positive

attitudes toward him, to enhance the parent-child relationship, and to provide them at appropriate times with information about how to meet his special needs."

Expectations and Intervention Strategies

by

Diane Nousanen and Steve DeRosa

Elsewhere in this manual we've talked about the advantages of home-based intervention. To make that intervention as productive as possible, the professional must work with the parent as a partner. The goal of the intervention is for the parent to become the child's primary teacher, advocate and case manager. The professional works with the parents to help the parents develop their own skills in rearing a handicapped child. It is more efficient if the professional teaches problem solving strategies to the parents rather than just trying to help with individual problems. Similarly, we present in this section ideas about, and strategies for, the professional so that he can help parents develop their own strategies for working with their handicapped children.

> "Give a man a fish and you feed him for a day;
> teach a man to fish and you feed him for a
> lifetime."--Chinese proverb.

Before starting to work with parents it is important for the professional to examine some of the expectations held by himself and the parents. These expectations are usually carried into the relationship without being examined. Performance tends to meet expectation. (Good and Brophey, 1969; Rosenthall and Jacobs, 1965). Conflict can arise if two people hold different expectations of

themselves in their relationship. If the expectations of both self and parents are examined, the reasonable ones accepted and the unreasonable ones modified, the professional can be more realistic in his demands of both himself and the parents and more straightforward in his relation with them.

What does the Professional expect of himself?

The expectations of the professional grow out of several influences. During his training, he was told what an educator is, what a psychologist is, what a therapist is, what a professional is, etc. He acquired a concept of the kind of professional he wanted to be. Once out of school he encounters society's concept of what kind of person works with handicapped children: one with "a lot of patience". Practical experience with children and other professionals modifies his expectations as he sees what he can and cannot do. If his expectations do not change with his experiences it is likely that his self-concept will be affected.

To help in forming realistic expectations it is useful for the professional to list his strengths and weaknesses along with his expectations of himself as a professional. Some typical expectations might be:

-I will always be available to my students.

-I will know all of the answers.

-I will have some answers, and know where to find others.

-I can only do so much for my students.

-It's my fault if the student does not progress.

-I will get along equally well with all of my students.

-I will get along equally well with other professionals.

-I will be able to identify the needs of my children and families.

-I'm not a good professional if I say I don't know.

-I know better how to work with children than parents do.

The first question to ask about expectations is "Do I really believe that?" If yes, then ask, "Can I fulfill that expectation?" If yes, go to the next one; if not, either strengths must be built up so the expectation can be met or the expectation must be changed. If the professional does not really believe the expectation, he must ask what he does believe and proceed with the questions about his strengths. If the professional's strengths exceed his expectations, it may be time to move to a new job.

What do the parents expect of the professional?

If the parents expect more of the professional than the professional can do, the parents will become disillusioned and dissatisfied with the services they receive. If the parents expect less than the professional can offer, they may be either pleased or intimidated by the additional intervention. Parents' expectations of professionals will be based on their previous experience with professionals.

"Every time I enter school, I feel like a kid again. I know it's silly for an adult, but I keep thinking somebody is going to order me around. Even good

schools - just by virtue of the fact that they are schools - seem to have a way of saying, 'we control you ', and the feeling that evokes in us as parents often interferes without abilities to create effective home-school relations on behalf of our children." --Francis Pobers, "You and Your Child's Teacher; How to Get along." Parents. May 1980, p.57.

One father, who was himself handicapped, reported that a home consultant had remarked how nice it was that a handicapped person could be gainfully employed. Although the consultant apparently felt the remark to be an innocent one made in a positive manner, it was apparent that the father did not take the comment well, and that was the cause for terminating their relationship. The event influenced the father's future expectations of consultant.

Some parents expect professionals to have all the answers and keys to working with "the system." Some expect the professional to work magic to make their child well again. This places the burden of the child's improvement on the professional and can lead to disillusionment and burn-out. Some parents have received only the run-around from other professionals so expect nothing at all when they meet a new professional. Some parents consider professionals to be unrealistic in their recommendations and may go along with what the professionals says while he's visiting and

ignore his suggestions the rest of the time. Parents Speak Out (1979) offers further insights into how professionals are viewed by parents.

Coming to terms with these expectations is difficult since the expectations will vary with the individual. The best the professional can do is to realize that they may exist, that the parents' reception of him may reflect one or more previous experiences. He can tell the parents what they can expect from him and then reinforce that by doing what he said he would do or explaining why he can't.

What does the professional expect of the parents?

Typically, professionals expect parents to be at home nurturing their children, to provide background information on the handicapped child, to cooperate in carrying out the home portion of the educational plan, and to have no other demands on their time. Since most professionals are not trained to work with parents, the professional feels uncertain when he finds he must become involved with parents. The professional tends to just tell the parents what to do without getting input from them. Then when the professional doesn't see the parents carrying through with the program he sees them as not caring about their child. He views the parents as an obstacle to the child's growth and development.

To form realistic expectations of parents one must look at other significant factors in their lives, their strengths and

weaknesses, and the ways in which they are coping with their child's handicap.

Ecological mapping (Hobbs, 1966) is one method for looking at the different influences impinging on the parents, so the professional can determine what demands on the parents' time and resources are reasonable. To prepare an ecological map of a family, "parents" is written in the center of a page. Around "Parents" the four strongest influences in the parents' lives are written. These can be people, places, things, or events. Not all of these influences will be positive, e.g., monthly bills. Then each of these influences is evaluated by placing a "+" next to those influences which enhance the parents' ability to help the child, and a "-" next to those influences which are a hinderance.

For example, the strongest influences for a family may be: both parents work, the grandparents babysit the child, the child has a handicap, and monthly bills are overwhelming. The home teacher has been trying to help the parents be the prime teachers of the child, but they haven't carried through with the program. Looking at the ecological map, it appears that the grandparents might be more suitable for carrying out the program with the child while the parents work to pay the bills. Thus the teacher is able to structure her goals within the exigencies of the family situation.

It has been repeatedly stressed that working with a handicapped child requires the joint efforts of both professional and parents. The professional has determined what skills he brings into the relationship; the same can be done with the parents. Thus the strengths of each can be combined for maximum effect.

Expectations the professional holds for the parents will depend to some extent on how the parents have adjusted to their child's handicap. This is commonly called the grieving process, though it might be more accurately called the coping process. It occurs whenever a person encounters a crisis such as death, divorce, failure to achieve a goal or some other traumatic incident. Parents of handicapped children go through a similar process in adjusting to their child's handicap. Most of the behaviors associated with the grieving/coping process are normal reactions. Olshansky (1962) writes that the grieving process is an adaptive behavior, not necessarily indicative of neurosis. Olshansky points out that grieving is often associated with pathological behavior because truly neurotic parents receive the most attention.

The grieving/coping process includes six stages: denial, guilt, anger, depression, bargaining, and acceptance. The process is not sequential and both parents may not be at the same stage at the same time.

The <u>denial</u> stage is typically characterized by a refusal to

accept the presence or severity of the handicapping condition. This may be because the person is experiencing shock and is not ready to deal with the situation. An example of a parent in denial might be one who says, "I know he's slow, but he'll grow out of it."

Anger is the emotion everyone has but no one wants to admit having. Frequently it is warranted. Parents of a handicapped child have a right to be angry; they didn't ask for a child with a handicap. This may be expressed as anger at the spouse or the self for having bad genes, anger at God for giving such a burden, anger at professionals who bring the bad news.

These feelings may change to depression (anger turned inward to contribute to a feeling of helplessness and hopelessness) or guilt (assuming responsibility for the child's handicap). Depression may be reflected in statements such as, "Things will never be any better than they are right now, and nothing I can do will help." Guilt may be expressed in statements such as, "If only I'd..., everything would be all right now" and "If I'd given up smoking the baby wouldn't have been damaged,"

Some people escape guilt or depression by bargaining. Bargaining is typically done with God: "God, if you'll help my child, I'll be a good parent; "I'll work for the church; I'll become a professional who works with handicapped children." Bargaining or denial may be expressed through searching for a cure, a treatment or a

more optimistic prognosis. Searching can be productive when combined with acceptance, or it can be dysfunctional if it is pursued at a cost of all other activities.

Each of these phases of the grieving/coping process must be evaluated on the basis of their impact on the family. If the parents are so depressed that they cannot carry out their regular activities, intervention is called for. If the parents can still function adequately and their state of coping does not interfere with the child's growth and development, intervention is not indicated. If it works, don't try to change it.

Acceptance is the phase where the parents accept their child as he is and deal with his problems in a realistic way. The child has a handicap but the handicap does not define the child. Some people reach a state of acceptance quickly and may not identify with the process by which they arrived at acceptance. Reaching a level of acceptance should not be considered permanent. The process may begin again as the child reaches adolescence or at other periods when the contrast with what might have been is striking.

Professionals also go through the grieving/coping process. They feel guilt when they are unable to help a child, become angry and blame the parents for lack of progress, bargain for greater skill by attending every workshop or lecture remotely related to helping "their children." As with the parents, none of these phases is "bad", and anyone can go through them. It is important that the individual recognize what is happening and accept it as

his method of coping with a difficult situation. Most people work through to a position of acceptance which is the preferred phase and which allows the individual to deal with his situation in the most realistic way.

A third method for helping to form realistic expectations of parents is to look at their individual needs. It is difficult to expect parents to meet the needs of their child until their own needs are met. Parents have needs for support, reassurance, information about handicaps and their effect of development, resources, instructions in parenting, meeting other parents of handicapped children, and so on. Most parents will not say what their needs are. A tool has been developed which can be used with parents to indicate in an objective way typical needs in the areas of knowledge of local resources, knowledge of child development, and the grieving process. This tool is called the Parent Needs Inventory and a description is included in Appendix II. Once specific needs have been indicated, the parents can decide if they want to do something about them, or say if they think something else is more important to them. A strategy for meeting the needs can then be planned. The professional also gains a clearer idea of what he can expect from the parents.

STEPS FOR CONSIDERATE INTERVENTION

The professional must keep in mind that he is working to support the parents in their own goals for themselves and their

child. The professional can suggest alternatives and point out things he thinks the parents may have missed, but unless the parents are involved in all aspects of the planning and programming they will not support it.

The first visit is important in setting the tone for the relationship with the family. If this visit can be arranged at a time when the father is at home he is given the option of being a participant. If he chooses not to be an active participant, he has at least been assured that he is important to his child's program, and he has had a voice in saying what direction it should take. He can be assured that he can meet with the professional or become more involved at any time.

In the initial visit it is best to limit the discussion to establishing a contract with the family. The professional describes the skills and resources he can offer, the method of service delivery, the professional's availability to the family, and how the relationship terminates. The parents as consumers can then decide if they are interested in the program, and if so, in which specific components. A tentative schedule is then set that fits into the family's routine and includes all who wish to be involved. The professional must be flexible in meeting the parents' needs. Perhaps the family prefers evening visits. Maybe the mother would like respite care an afternoon a week so she can have time to shop or be with her other children. If there are a great

many demands on the family perhaps the program needs to be slowed down for a while until the pressures ease.

Sometimes it may be necessary to delay work on an important skill to work on one which concerns the parents more. For example, one parent consultant had set up a program with a family. The weekly activities were being carried out by the family with little enthusiasm. Then the parents commented that they were concerned because the child wouldn't eat his vegetables. The consultant developed a program which persuaded the child to eat vegetables. The parents were shown that the professional was interested in their concerns, and that they could be successful in programming for their child, and they then participated in other aspects of the program with greater interest.

Part of the professional's role is to help the parents find information and to show them how to work through the system on their own. This may include visiting the ophthalmologist with the parents to get answers about the child's condition in understandable language. The professional thus models how to get more complete information from the doctor and encourages the doctor to be more lucid with his patients. Finding information may include calling eight different people in four different agencies to get an answer to one question. The parents can see that finding information is not always easy, but can usually be accomplished with persistence. The professional must be willing to refer to

other agencies and services when the need arises. The situation becomes more confusing as more professionals are involved. Each person involved must make every effort to communicate with each other so conflicting information is not given, and so the family is not overwhelmed with visitations. It may be necessary for one or more professionals to bow out for a while. The decisions for each of these options should rest with the parents and be supported by the professional.

The professionals' role is to help the parents function more effectively so they can better achieve their own goals. The professional's job is to work himself out of a job. He is helping parents to be the case managers for their child.

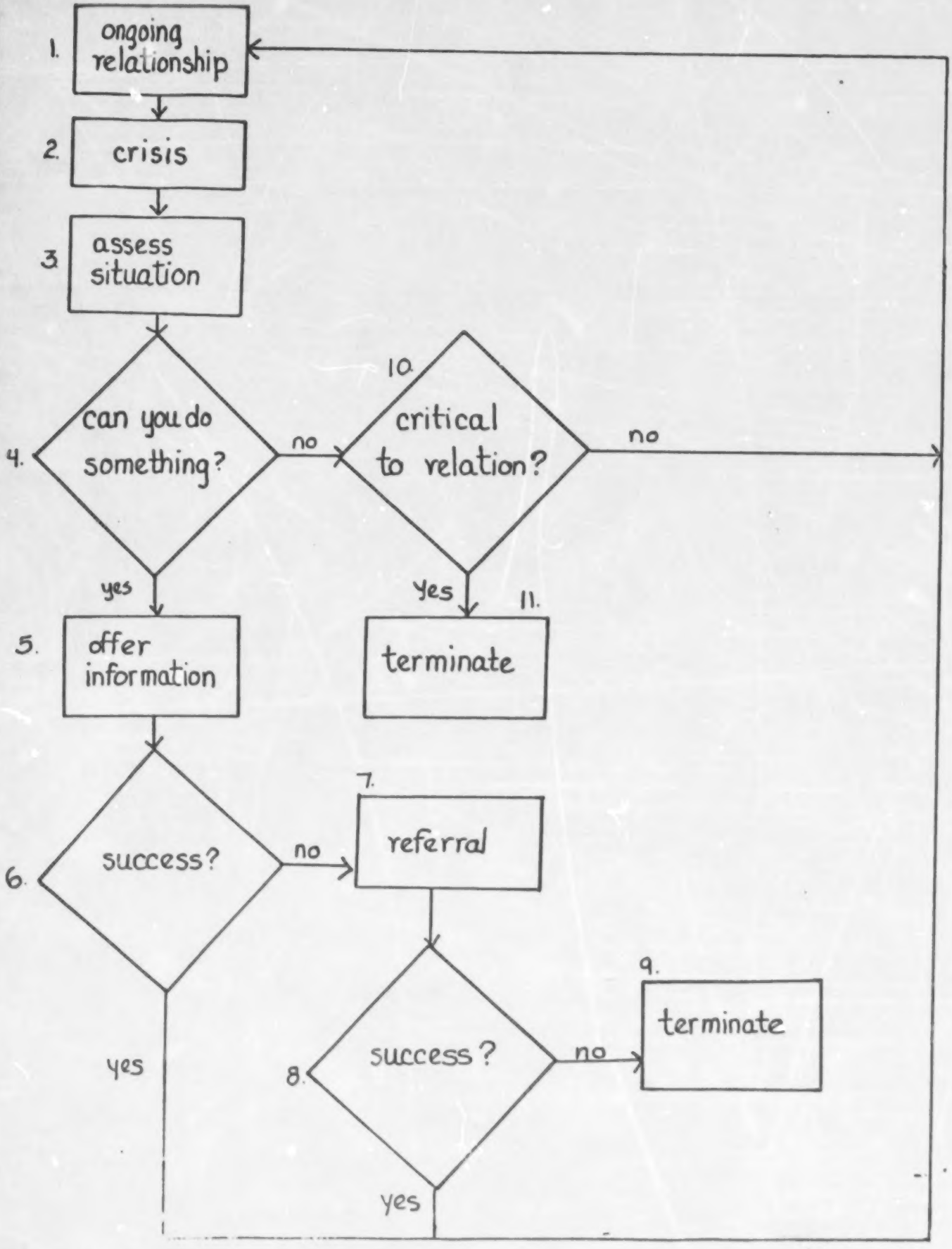
The professional-parent relationship is especially a sharing one. Each has skills; each has limitations. If they can admit both to each other they have the beginnings of honesty with each other and an understanding that the other is important. They have also formed a basis by which they can each learn and grow.

PROBLEM-SOLVING

Having established a program for the handicapped child and a relationship with the parents, problems may arise which seem to interfere with the child's progress or the relationship with the parents. Often the professional will try to continue as if nothing is wrong while the situation gets worse. Or the professional may just react without thinking through a strategy. A more

methodical approach is to examine the problem, consider methods for handling it, select one, evaluate its success, and so on. It is important for the professional to accept his own limitations and to make referrals to other professionals when a skill beyond his own is required. He must also be willing to accept that there may be situations from which he must withdraw; it is better to terminate an unproductive relationship than to continue in it and create hard feelings and frustration for everyone.

The flow-chart on page 62 depicts steps to be followed in problem-solving and determining when it is advisable to terminate a relationship. The chart begins with the on-going relationship (Step 1). A crisis or problem occurs (Step 2). After assessing the situation (Step 3) it must be determined whether or not something can be done about it (Step 4). If nothing can be done and the issue is critical to the relationship (Step 10) may be necessary to terminate the relationship (Step 11). If the issue is not critical, the relationship continues (Step 1). Resolving the crisis will probably involve offering information (Step 5). In Step 6 the usefulness of the information in resolving the crisis is evaluated. If the information was appropriate and successful in solving the problem the relationship continues (Step 1). If not, a referral to another source of help is made (Step 7). The success of the referral is then evaluated (Step 8). If it was successful the relationship continues (Step 1); if not, terminate (Step 9).


1. ongoing relationship
2. crisis
3. assess situation
4. can you do something?
no
10. critical to relation?
no
yes
Yes
11. terminate
5. offer information
6. success?
no
7. referral
yes
8. success?
no
9. terminate
yes

The scheme is highly simplified. Several loops are implied. Referral to another source of help, for example, may occur several times before one is found that is successful. The process of problem solving remains the same: assess the problem, decide on a solution, try it, evaluate. The plan forms a structure for evaluating one's effectiveness in the relationship and for deciding when termination is warranted and when it is not.

Four situations are given below which illustrate use of the flow chart and which the reader may use for practice.

Example I:

(Step 1: Relationship) During a home visit, a sibling of the handicapped child constantly disrupts the conversation by doing somersaults through the living room. The parent tries to control the child with verbal threats, but without success. (Step 2: Crisis) Since the child is disrupting the visit there is a need for intervention.

At Step 3 of the scheme, the situation is assessed. The problem centers around the sibling's behavior, so a behavioral assessment is appropriate: what are the antecedents and consequences of the sibling's behavior? The parent and professional discuss the circumstances under which the behavior occurs and realize that it happens during home visits and at other times when the parents pay special interest to the handicapped child. When the sibling becomes disruptive the parent stops and admonishes him. The result of the disruptive behavior is parent

attention, albeit negative attention.

Step 4 asks: can you do something? Answer: yes. The professional offers possible strategies (Step 5). Having decided that the sibling's behavior is an attempt to get the parent's attention, because so much time is focused on the handicapped child, the solution suggested is: (a) the professional will bring a special toy for the sibling, as he does for the handicapped child, (b) the parents will set aside special time for the sibling, and (c) the sibling will be included in the activities for the handicapped child. The strategy is successful (Step 6), and the parent and professional are able to return to their ongoing relationship (Step 1).

Example II:

The second situation involves a choice between professional services. The family is composed of a mother, father, and a two-year-old multihandicapped daughter. The child qualifies for two programs: the local center-based program of the school district, and combination home and center-based program from the county mental health-mental retardation agency. The parents are unsure which program will best meet the child's needs. Beginning at Step 3 assessments are made - a developmental assessment of the child and an evaluation of the parents' needs relative to the child. Obviously something can be done through services provided by the two different programs (Step 4). Information about each

program is required so that an informed choice can be made (Step 5). Perhaps a trial placement may be made. The success of this placement must then be evaluated (Step 6).

Example III:

This situation involves a family where the parents as well as the child are handicapped. A professional has been involved with the family for a year, but there has been little progress in the child. The mother seems to enjoy the visits but is not consistent in carrying out the programmed stimulation activities. The professional feels that something must be done because the child is falling further behind the developmental level for his age. The mother feels that the child will catch up on his own and that it is natural for the child to be behind because of his handicap. She does not seem to perceive a problem in the child's lack of progress.

After assessing the situation, it appears that nothing more can be done to change it. Because the mother will not participate in the program under the contract previously established, the relationship is terminated. Note that in this situation the professional saw a problem that the mother did not perceive. Since the apparent basis for their relationship was working with the child's developmental delay, it became no longer feasible to continue the relationship.

Example IV:

In this situation there is a family with three children and the mother only. The oldest child is a profoundly handicapped

young adult. The mother has kept the child at home with the other children because she felt that was best. However she now feels that most of her time and energy is spent caring for the handicapped child to the detriment of herself and her other children.

Assessment has shown that the mother no longer wants to keep her handicapped child at home. Information about different residential centers and respite care facilities can be provided. The mother chooses one which she feels will be satisfactory, and a placement is made. The success of the placement will be evaluated later.

Conclusion:

This section has set forth a philosophy and a guide for working with parents of handicapped children. In dealing with parents it is important to remember that the parent is a person first, a parent second, and a parent of a handicapped child third. It is equally important to remember that the professional's relationship with the family is temporary, but the parent will always be a parent. For this reason, it is best to view the parent as the child's best advocate and most appropriate teacher. To restate the chinese proverb: Solve the problem for the parent, and you've solved the problem; teach the parent to solve his problems and you've solved many problems.

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APPENDIX I: THE VISION-UP CURRICULUM

INTRODUCTION

The Vision-Up Curriculum is a program that provides a method of assessing, programming and evaluating a child's developmental activities. The curriculum is being used successfully with blind, visually impaired, deaf-blind, retarded and multihandicapped children in all 50 states, Canada, Israel, New Zealand and Australia. It has been translated into Spanish, French and German.

Multi-sensory approaches to learning are emphasized throughout the program. Auditory, visual, tactile and kinesthetic methods are used to facilitate and reinforce learning. Jean Piaget's work in child development provides a theoretical foundation.

An important advantage of using the Vision-Up Curriculum is that parents are involved in all phases of the assessment, programming and evaluation. The step by step activities serve as a way for parents to learn more about child development. Parents appreciate the fact that the results are always stated in a positive manner so that the child's strengths, not his limitations, are emphasized.

Teachers and other caregivers like the Vision-Up Curriculum because it pin-points specific activities for working with the child. These activities can be incorporated into the child's Individualized Education Program. By determining the child's correct functioning level, it is easy to group children with

similar needs for teaching purposes.

The curriculum focuses on six areas of development: fine-motor, intellectual, language, physical, self-help, and social-personal. Each of the six developmental areas is divided into groups of major skill areas called sequences. Each sequence contains specific behavioral skills which are arranged in the order they occur in normal child development. For example, the fine motor development area is divided into six sequences: hand-use, visual-motor, object manipulation, and so forth. The finger-use sequence consists of twenty-six skills such as "The child is able to string at least four beads".

The Piagetian theory upon which the curriculum is based, a description of the kit contents, instructions for using the curriculum materials and practice exercises are included in this chapter.

PIAGETIAN DEVELOPMENTAL THEORY*

The fundamental concepts of the Vision-Up Curriculum are founded on the child development theories of Jean Piaget. Piaget theorized that the order of a child's growth and development is fixed, but the rate of development is varied due to the influence of four distinct developmental factors. He hypothesized that four factors --organic growth and maturation, social interaction and transmission, physical experiences, and equilibration--were the basis for mental growth and that from observing these factors it can be determined that reasoning does not develop spontaneously. A brief discussion

of each of the four factors follows.

The first factor, organic growth and maturation, plays a role in that biological development influences the stimuli which are received by the child. Although an important factor, maturation alone does not explain development, for maturation must be reinforced by functional exercise and experience (Piaget and Inhelder, 1969).

The second factor, social interaction and transmission, is a process in which the individual contributes as well as receives. In this way the child learns from others (Piaget and Inhelder, 1969). These transmissions include the verbal instructions transmitted by teachers and parents. Frequently this is characteristic of the process of education in many schools today.

The third factor in cognitive development is physical experiences. Piaget characterized this into two parts. First, physical experiences are those which consist of acting on objects in order to abstract their properties. For instance, squeezing an orange gives the child a tactile sensation of roundness, roughness, and pliability, the visual sensation of color, the smell of the orange, and the taste of orange juice when the orange is sucked. The second part of this experiential factor is the logico-mathematical experiences which consists of acting on objects in order to learn the results of the coordination of these actions. (Piaget and Inhelder, 1969). Piaget gives the example of a mathematician

who began his career early in childhood. When the mathematician was about four or five, he was playing by the beach with some pebbles; he put them in a row and counted, then he counted the row backwards and found that the number was still the same. He tried re-arranging them into a circle and was surprised to find that there were still the same number of pebbles. With this experience, the young mathematician began building his understanding of number constancy (Pulaski, 1971).

The fourth factor is a more general factor which coordinates the three previous ones. Piaget called this factor equilibration. This process involves a series of active compensations on the part of the child (Piaget, 1967). Equilibration coordinates the organic, social and physical factors in a consistent contradictory way. Equilibration is composed principally of two parts, accommodation and assimulation. As equilibration occurs, the child assimulates information which comes from the organic growth, social interaction, and physical experience factors while accommodating to subtle differences in this information. Piaget (1967) has described mental development as a continuous construction similar to the erection of a large building that becomes more stable with each addition. In other words, the reality of the situation is assimulated into the child's existing mental structure while at the same time the structures are accommodating to the actual situation (Simpkins 1976). As an example, you are using these processes

even now. You are reading the description of them and attempting to absorb the information which is similar to assimulating the information. But if this is all new and different for you, then you must accommodate this information to other processes you have already learned prior to reading this material.

Each of these four factors plays an important part in the development of cognitive awareness in the child. A handicap can impair or slow down the receipt of information from any of these four elements resulting in misinformation and a poor conceptual grasp of what is to be learned. For example, equilibration is dependent upon the quality as well as the quantity of information received from the other three factors in order to coordinate these data in a consistent way. In an early and extensive study of cognitive development of blind children, Atwell (1966) inferred that blindness created a "...rupture of equilibrium between assimulation and accommodation." Blind children assimulated information through generalizations that may have been deformed or maladapted. Since less pressure is exerted by the outside world, blindness impairs the ability to accommodate. A study of cognitive patterning in congenitally blind children (Woodkin, Burnbom, Lomonaco, Lehr, and Herman, 1968) found that perception in both blind and sighted children proceeded from global to articulated (general to specific) but that blind children were less articulate in their cognitive functioning. Because of the previously cited limitations, blind

children often assimulated at no more than a verbal level. For instance, a nine-year-old boy told his teacher how surprised he had been on a family trip when his father did not become tired after an hour or so of driving. When the father inquired as to the child's reason for this concern, the boy explained that he would have been tired by now if he had to do all that pedalling. To this child, the gas pedal had been associated with his bicycle pedal. He had assimulated the idea of a pedal, but his physical experiences had not forced him to accommodate the verbal pedal to various types of pedals. Pedals in an automobile were understood only at a verbal level (Simpkins, 1967c).

How does one determine the present level of a child's mental development? This question is answered readily through a study of the stages of development outlined by Piaget. These stages form the basis from which the Vision-Up Curriculum was structured. Those items composing the section on Intellectual Development are based directly on Piaget's stages of cognitive development. Figure 1 reviews the stages of development.

Figure 1

SENSORY-MOTOR (Approximately birth to two years)

Development from a state of reflex activity to an organized sensory-motor action system.

(a) REFLEXIVE (0-1 month)

Simple reflex activity; e.g., kicking

(b) PRIMARY CIRCULAR REACTION (1-4-5 months)

Reflexive behavior elaborated and coordinated; e.g. a thing grasped becomes something to suck.

(c) SECONDARY CIRCULAR REACTION (4.5-9 months)

Repeats chance actions to reproduce an interesting change or effect; e.g., kicks crib, rattle shakes, so kicks crib again.

(d) COORDINATION OF SECONDARY SCHEMA (9-12 months)

Acts clearly intentional; e.g., reaches behind cushion for ball.

(e) TERTIARY CIRCULAR REACTIONS (12-18 months)

Discovers new ways to obtain desired goals; e.g., pulls pillow nearer in order to get music box resting on it.

(f) INVENTION OF NEW MEANS THROUGH MENTAL COMBINATIONS (18-24 months)

Invents new ways and means; e.g., uses stick to reach desired object.

PREOPERATIONAL (Approximately 2 to 7 years)

Perceptually oriented, makes judgments in terms of how things appear, generally deals with only one variable at a time. Thought is rigid.

(a) PRECONCEPTUAL (2-4 years)

Capable of deferred imitation and of verbal expression; speech is repetitious; frequent egocentric monologues.

(b) INTUITIVE (4-7 years)

Speech becomes socialized; reasoning is egocentric; e.g.,

"to the right" means to his right.

CONCRETE OPERATIONS (Approximately 7 to 11 years)
Mobile and systematic thought organizes and classifies information. Can follow successive change through various types of detours and reversals. Operations are tied to action, they are concrete rather than abstract.

FORMAL OPERATIONS (Generally achieved after age 11)
Ability to think abstractly, formulate hypotheses, engage in hypothetico-deductive reasoning, and check solutions. Thought now directs observations.

Figure 1: Piaget's Stages of Development (Selected from Dr. Katherine Simpkins' Instructional Materials Department of Educational Psychology, Brigham Young University. Used with permission of Dr. Simpkins.)

The sensory motor stage characterizes Piaget's first stage of the child's functioning and concerns the child's development from birth to approximately two years. During the time, the child moves through six substages from a primary reflexive organism to one with a more organized system of behavior (see Figure 1). Marshall (1975) states that from the behavior of a three or four month old fetus, it is obvious that the brain is "capable of organizing quite complicated responses to stimuli at this age" (page 43), allowing the fetus to open its mouth, turn its head sideways or move through the sensory motor stage to the invention of new means to obtain new ends. For example, a child at this functional level might use

grandpa's cane to retrieve a toy after having thrown it from the playpen (Simpkins, 1976).

During the preoperational stage, the child is unable to use logical thinking. Judgments are based primarily on perceptual cues and generally on the basis of one variable at a time. Therefore, the child's reasoning is characterized as egocentric; things are as they appear to him at a particular time and place. There is a lack of constancy in his judgments since they may change when any one variable changes in relation to himself.

For example, suppose that a young child of about three years asks his mother for a glass of milk. The mother finds the carton of milk almost empty, but pours the rest into a large glass. The child begins to fuss, explaining that the glass is not full. Patiently, the mother explains that there is no more milk, but there is no quietening the child. Suddenly, a Piagetian scholar enters the room. Understanding the situation immediately, this astute person takes a small glass and pours the milk into it, filling the small glass to the brim. Now the child grins and says that's what he wanted--a full glass of milk (Simpkins, 1976). The height of the glass was the only relevant variable to the child.

In the concrete operational stage, logical thinking begins to emerge. The child is able to go through a series of transformations, detours, reverses and other changes to obtain a successful solution. No longer would this child be fooled by the size of a

drinking glass. The child would know that a change in size or shape of a container would not change the amount of milk. But these observations are still tied to the concrete observable reality of the situation.

An example of concrete operational functioning is seen in the child's attempt to classify large, medium and small circles into groups. Initially the grouping may be done on the basis of shape, but the reality of the various sizes of pieces would be assimulated into existing mental structures, forming an awareness of the simultanity of the two criteria, i.e., size and shape. However, since previous classification schemas for this child dealt primarily with only one criterion, accommodation would be necessary to extend the classification structures to two criteria simultaneously. As the assimulation and accommadation processes combine, the concept of shape and size as simultaneous properties of the pieces would develop so the child would be able to sort on the basis of these two criteria. Now the child can group them into large circles, large squares, medium circles, medium squares, etc. This overt action would suggest that the child's underlying structure for classification has been extended to include classification by two criteria simultaneously.

The final state in Piaget's stages is that of formal operations and emerges around 11 or 12 years of age and carries the child into adulthood. This stage is characterized by the ability to perform

abstract reasoning, similar to the scientific method which involves defining a problem, formulating hypothesis, engaging in hypothetical deductive reasoning, carrying out systematic experimentation, forming conclusions from records based on experimentation and then checking these conclusions against existing criteria.

*(The above discussion of Jean Piaget's theory was taken principally from a presentation by Dr. Katherine Simpkins during a Project Vision-Up workshop conducted at Brigham Young University, 1977. No bibliographic references were included.)

CONTENTS OF THE VISION-UP KIT

The Vision-Up Curriculum Kit consists of 910 program cards, two sets of the card sort assessment tool, 20 initial response forms, 20 profile charts, 20 data sheets and one curriculum handbook. Each of these items is described below.

Program Cards

The program cards provide the framework for the curriculum and list activities to assist the child in moving along normal patterns of development. The program cards are color coded by area of development:

Fine Motor (FM): Orange	Physical (PD): Pink
Intellectual (ID): Blue	Self Help (SH): Green
Language (LD): Yellow	Social Personal (SP): White

Each program card contains the following information:(See Page 94).

A 'number/letter code" is printed on the upper left corner of each card (e.g, 60SP36*). The code is used throughout the curriculum and coordinates the behavioral skill on the program cards, the curriculum handbook and the profile chart. The item number of the card is the number preceding the letters. The letters are the initials of the area of development; the number following the letters is the average age in months at which the child might be expected to accomplish the task. A "W" after the number signifies that the age is stated in weeks. A plus sign (+) following the number indicates continous development of the skill described on that card extends past 72 months. An asterisk after the code indicates that the item number is represented in the card sort assessment tool.

In the example on the next page, the number/letter code 60SP36* means that this card is item number 60 in the Social Personal (SP) developmental area, that the child might be expected to accomplish this task by the age of 36 months and that this card is one of the items in the card sort.

A "teacher information code" is located in the upper right corner of the card. The top line indicates the sequence within the area of development and the placement of that card within the sequence. Also indicated are the preceding card in the sequence and the following card in the sequence, so those cards can be

quickly located.

The "title" of the program card gives a brief description of the skill and is used for indexing the cards.

The "behavioral description" is an expanded statement of what the child can be expected to do after completing the program outlined on the card.

The "programming" section lists activities that can be used to assist the child in learning the skill.

"Indications of Disability" are listed on some of the cards and signal the teacher to consult the appropriate clinician if the child demonstrates unusual symptoms or has extreme difficulty learning the skill.

The "materials" section lists materials which can be used to assist the child in developing the skill.

The backs of the cards may be used by teachers and parents to record suggestions, comments and data for future use.

Card Sort Assessment Tool

The card sort assessment tool allows parents to identify skills their child can complete and provides the starting point for evaluation of the child.

The card sort consists of 4" x 6" cards which sample about 25% of the program cards and are color coded to match the six developmental areas. Approximately 40 cards have been selected from each area on the basis of overall developmental importance

and relation to other cards. Each card is printed with the number/letter code as on the program card, the name of the sequence, the number of the card in the sequence and the behavioral description.

Take a moment to compare and contrast the program card printed on page 94 and the card sort assessment card below.

60SP36

SOCIAL INTERACTION - 40

The child shows signs of affection, pity, guilt, and other emotions.

Initial Response Form

The initial response form provides an overview of the child's functioning level. The seven page form also serves as a permanent record of the child's beginning skill levels. (In the early editions of the Vision-Up Curriculum, this form was called the Initial Response Questionnaire.) A copy of the initial response form is printed on pages 95 to 101.

Profile Chart

The profile chart provides a method of recording the child's present level of functioning, the areas of his strengths and weaknesses and his developmental progress. Responses may be recorded on either of two profile charts. One chart displays development through the child's first six years; the other chart, called the "Infant Profile Chart", provides an expanded view of the first two years.

Using the Infant Profile Chart for children under two years of age gives the parent a more encouraging view of the child's progress since it shows only the behaviors the child is expected to complete by age two, instead of comparing him to a child of six years.

Each profile chart lists each of the six developmental areas and all of the sequences appropriate to the age group on that chart. The chart contains numbered boxes representing each of the skills on the program cards. The vertical lines on the chart represent developmental rather than chronological age levels.

Additional information about the child is kept on the reverse side of the profile chart. The child's age, sex, and setting for programming are indicated in the identification section. The middle section indicates the evaluations which have taken place or need to take place. A summary of the impairments identified by professional examinations is given in the bottom section. There is also an area on the profile chart to record standardized tests

which have been administered to the child. A sample profile chart is included on page 102.

The early editions of the Vision-Up Curriculum do not contain the Infant Profile Chart. Copies may be ordered from Educational Products and Training Foundation, P.O. Box 4128, Boise, Idaho 83704, or Consultant Services, Inc., 4304 Balcones Woods Drive, Austin, Texas 78759.

Data Sheets

The data sheets are used to monitor the effectiveness of the programming by providing a record of the child's daily progress in the selected tasks. A sample data sheet is printed on page 103.

Curriculum Handbook

The curriculum handbook contains instruction in the use of the Vision-Up materials and several indexes helpful for identifying starting points, for locating programs quickly, and for obtaining an overall view of each area and sequence.

Each section of the handbook is identified by a color coded title page that corresponds to the color of the program cards. For example, the title page for the physical development section is pink. A numerical index follows each title page and lists all of program card titles from that developmental area. This list shows the inter-relationship of all activities in the developmental area and shows, in a general way, which items in a sequence are pre-requisites for items in another sequence. A page from a numerical

index is printed on page 105 of this manual.

Following the numerical index in each section is a sequence index, listing all of the cards in each sequence in order of developmental age and by behavioral description. (See page 104.) Underlined items indicate items that are included in the card sort.

In the back of the handbook is a list of suggested materials such as toys, building materials, and sound sources that can be used in programming activities. Most of the items are inexpensive and can be found in the home or classroom. The items are meant to be suggestions and can be substituted and/or supplemented with materials which can be used for the same purpose. Try not to relegate common household items to their original functions only, but, whenever possible, use them in other ways for teaching the child. For example, a set of metal kitchen canisters can be used to teach a child to sort sizes. A sample page from the materials index is printed on page 106 of this manual.

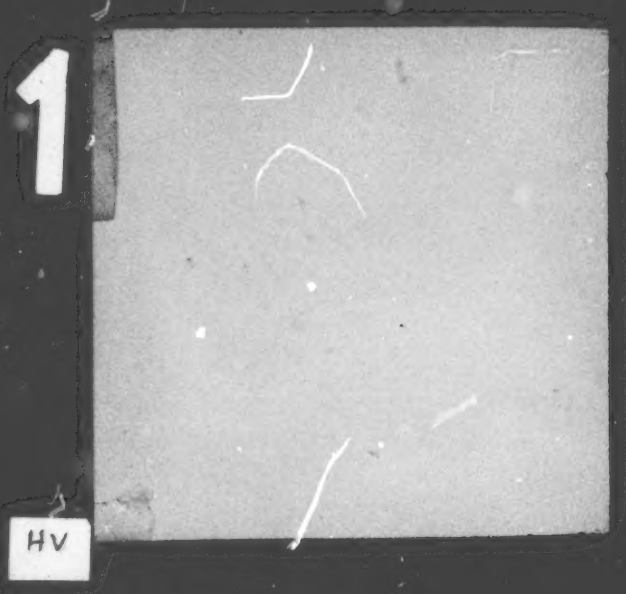
INSTRUCTIONS FOR USING THE VISION-UP CURRICULUM

There are eight basic steps involved in using the Vision-Up Curriculum. These steps, listed below, are described in detail in the following pages.

Step One: Complete the card sort assessment.

Step Two: Record the card sort responses onto the initial response form.

Step Three: Begin the profile chart by coloring the boxes representing the "yes" responses.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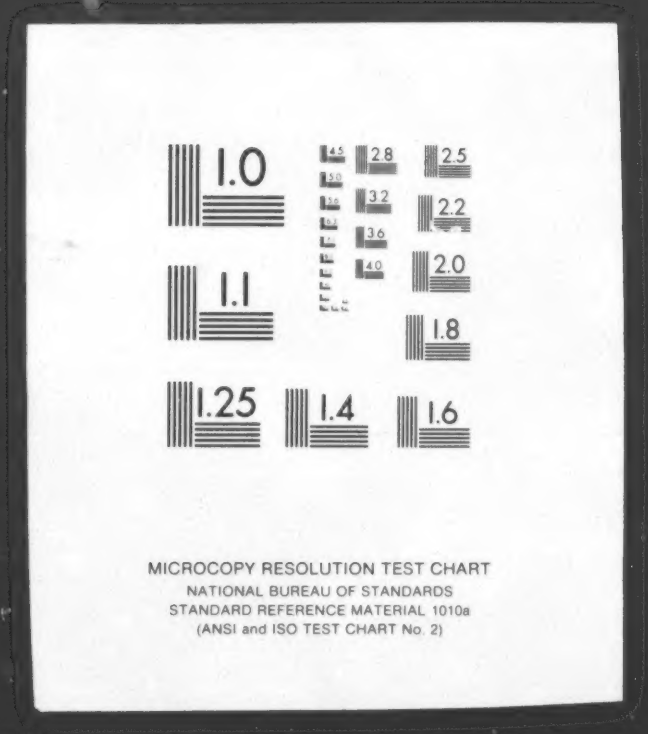
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MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS
STANDARD REFERENCE MATERIAL 1010a
(ANSI and ISO TEST CHART No. 2)

Step Four: Verify the highest level of functioning in each of the sequences on the profile chart.

Step Five: Complete the profile chart by coloring all items below the highest number completed in each sequence.

Step Six: Select the program cards to be used.

Step Seven: Complete the data sheets.

Step Eight: Note indications of disability.

It will be helpful to pull the appropriate items from the Vision-Up Curriculum kit and examine them as you read the following instructions. A sample profile chart that contains examples is included on page 102. Please refer to this profile chart as you read the instructions.

Step One: Complete the Card Sort Assessment.

Have the parent separate the card sort assessment cards into three stacks by having him/her read the behavioral description on each card and decide:

(a) YES, the child can do this task, or

(b) NO, the child cannot do this task, or

(c) NOT SURE if the child can do this task, or the child does this task SOMETIMES.

The presentation of the cards should be adapted to the needs of the parents. For example, present one developmental area at a time, or provide cards with the words "YES", "NO" and "SOMETIMES" on them to make the card sorting an easy and relaxed procedure.

You should be present to answer questions while the parents sort the cards. Many times, the questions and comments made by the parents during the assessment will help you better understand the parents' attitudes and expectation levels.

The card sort assessment usually takes less than an hour to complete. To save time, you can record the responses from one developmental area while the parent is sorting the cards in another area.

The card sort assessment tool contains fewer than twenty items that are appropriate for very young or extremely handicapped children. Thus, a card sort assessment for these children will result in relatively few "yes" responses. This can be discouraging to the parent. There are two ways of conducting the assessment that will result in a greater number of positive responses. One way is to read to the parent all of the behavioral descriptions from the curriculum handbook which are appropriate to the child's age. Record the responses as the parent answers "yes", "no" or "sometimes".

Or, reduce the number of cards in the card sort by giving the parents only the cards representing the child's developmental age, the year preceding his age and the year following his age. Although this <u>will</u> reduce the number of negative responses, it will not identify the child's functioning level as well as reading the behavioral descriptions to the parents.

Step Two: Record the card sort responses onto the initial responses form.

The initial response form lists each of the card sort items. Complete the form by circling the appropriate letter representing "yes" "no", or "sometimes (?)" as indicated by the parents during the card sort assessment. (See the example on page 96.)

A pattern usually develops as the responses are recorded. At first there is a series of all "yes" responses, then a mixture of "yes", "no", and "sometimes" responses, and finally a series of "no" responses. If this pattern does not develop, check carefully to see if there is a logical explanation such as a physical disability. Very young or severely handicapped children will have a pattern that is completed after relatively few responses.

Step Three: Begin the profile chart by coloring the boxes representing the "yes" responses.

First arrange the cards by sequence within each developmental area. For example, in the Fine Motor area, compile all of the cards in the hand-use sequence, then those in the visual-motor sequence, the object manipulation sequence, and so forth.

Next, identify the item number on the card. This is the item number to be colored on the profile chart. To locate the corresponding item number on the profile chart:

(a) Locate the developmental area along the extreme left column.

(b) Find the appropriate sequence in the area on the adjoining column. (Note: On profile charts printed before

May 1979, the developmental areas and sequence names are located on the right side of the profile chart.)

(c) Move to the right until you find the correct item number. Color this box. For easier reference, all of the boxes representing item numbers in the card sort are shaded gray on the profile chart.

Complete this process until you have colored all of the numbered boxes on the profile chart that represent the "yes" responses of the card sort completed by the parents.

When the child is evaluated in the future, mark the profile chart with another color, keeping a record of the dates of evaluation and the color used to record them.

Step Four: Verify the highest level of functioning in each of the sequences on the profile chart.

On the profile chart, locate the highest item number the child has completed in each sequence. Identify the next higher number in that sequence (not necessarily the adjoining number on the profile chart). By using the behavioral description on the program card or in the sequence section of the handbook, determine if the child can complete the higher task. For example, if the card sort assessment indicated that the child could complete item number 13 in the Self Help area, dressing sequence, check to see if he can complete item number 32, which is the next higher number in that sequence.

If the child cannot complete the higher task, return to the preceding item in the sequence and check to see if the child can complete that task. If the child can complete the task, color the appropriate box on the profile chart and verify that the child can complete the next higher item number.

Continue this process until the child's highest functioning level is found in each sequence. After completing step four, the profile chart will appear spotted.

Step Five: Complete the profile chart by coloring all items below the highest number completed in each sequence.

In most cases, it is assumed that if a child can complete a specific item, he can complete the items below that number. Therefore, to avoid verifying every item on the profile chart, color the items below the highest number completed in each sequence. For example, if number 27 is the highest item achieved in the Language Area verbal behavior sequence, color all boxes preceding box 27 in this sequence.

There are some exceptions to this assumption. Note that some boxes do not have numbers in them. Color these boxes up to the vertical line that represents the child's developmental age. For example, there are no numbered boxes in the sensory discrimination sequence beyond the 5-8 month level. If the child is older than 5-8 months and has completed all of the items in the sequence, these boxes should be filled in through his age. On the sample profile chart, the sensory discrimination sequence has been filled in for an 18 month old child. If you are using the profile chart for 0-6 years, there will be more boxes without numbers since such boxes have been eliminated on the Infant Profile Chart.

A splinter skill is a skill which is far above the general performance level and which as few or no supporting skills at previous levels. When a splinter skill appears on the profile chart, it means that either the child cannot complete the supporting items and/or that there is a large age span between the items. Color the actual splinter skills but do not color the boxes between the

splinter skill and the preceding colored items.

An example of this is shown in the head control sequence of the Physical Development area on the sample profile chart. The card sort yielded "yes" responses for item numbers 1, 26 and 53. However, when the child's highest level of functioning was determined, as in step four, it was found that he could not perform the tasks between items number 26 and 53. Therefore, these items were not colored, but the items below number 26 were colored.

As each sequence is filled in, a definite picture of the child's abilities and weaknesses will appear. It is important to fill in all of the boxes as indicated, to insure that the profile chart is as complete as possible. A chart that is not filled in correctly will not provide a good picture of the child's abilities.

Step Six: Select the program cards to be used.

To locate the appropriate program card to be used, locate the highest number completed in the sequence. Since the child has already mastered this behavior, the next higher number in the sequence is the item number of the program card to be selected. For example, item number 7 is the highest number completed in the walking sequence of the Physical Development area, so item number 23 is the program card to be selected.

There are three considerations in selecting program cards. These are (1) the areas of deficiency, (2) the relationship between

sequences, and (3) the parents' desires.

The completed profile chart will show any areas of deficiency the child may have. Sequences which fall short of the average age of achievement will need programming.

Some areas of development are interrelated. For instance, certain gross motor skills must be developed before fine motor skills can be mastered and intellectual skills must precede language skills. Program cards should be selected according to the prerequisite skills needed.

The programs selected should be based on the parents' interests. For example, even though the profile chart may indicate that Physical Development is the area most in need of programming, it may be better to stress Self Help skills if that is of most concern to the parents. It is important to select programs according to parents' interests because motivation and success are especially important to them in the early stages of programming. Later, as the child progresses, the parents will see the need to stress the areas indicated on the profile chart.

Step Seven: Complete the data sheets.

As individual activities are selected for the child, data sheets should be kept of the child's efforts to accomplish the task. The teacher or parent should complete the data sheet by marking an "O" whenever the child is unsuccessful at completing the task, and a "+" whenever the child is successful, and "P" when

the child participates in the activity but does not complete it.

As indicated in the example on page 103, the child showed no progress in the beginning although there were many attempts. After a few days the child was still not successful, but began to participate in the exercises. This is indicated with a notation of "P". Finally, the child completed the task four times and met the criteria established by the teacher. The final notation is the teacher test. Here, the teacher observed the child perform the task as described in the behavioral description.

In general, the minimum standard for the completion of the task is four successful tries out of five. However, the criteria might have to be changed depending on the child's handicap. For example, a child with severe seizures who seems to make progress one day, but looses progress the next day may require a criteria level of ten successful tries several days in succession.

In some cases, the data sheet may be too rigid a recording procedure. Actually, any kind of notation system is acceptable as long as it reflects the progress of the child. Circumstances involving the parents and the child may necessitate using your judgment in selecting the criteria to be used.

Without making the parents feel inadequate, you should verify that the child is actually able to complete the task because the parents may have unintentionally made the task more or less difficult. It is important for the teacher to help the parents

assess the quality of the child's performance as well as the presence or absence of the behavior.

Step Eight: Note Indications of Disability.

In cases where the child indicates extreme inability to develop new skills in an area suited to his age, make a referral to an appropriate clinician to determine if a pathological condition exists. This applies to all tasks, but make special note on the program cards marked "Indications of Disability".

When consulting a clinician, show him the profile chart and the selected program cards and ask for opinions and suggestions concerning the activities.

60SP36*

AREA: Social Interaction - 40
PRECEDING CARD: 59SP36
FOLLOWING CARD: 51SP36

TITLE:

Shows Signs of Emotion

BEHAVIORAL DESCRIPTION:

The child shows signs of affection, pity, guilt, and other emotions.

PROGRAMMING:

1. The parents should display affection to the child both verbally and physically. As the child begins to respond to his parents' display of affection, he will begin to express himself in affectionate terms to others he feels close to. He should learn to be selective about those he displays affection to, however.
2. If possible, provide the child with a pet. Caring for another life and providing its needs helps develop positive emotional responses.
3. Provide the child with a doll and with opportunities to imitate real life situations in which emotions are expressed.
4. Express your own emotions openly but not in excess in front of the child so that he is aware of the wide range of emotions and what causes these emotions. Try to make sure your emotional responses in front of him are appropriate to the situation.
5. When the child feels bad that a member of his family or his pet has been injured, is cold, or sick, he should begin to feel and express pity. Often as a result of having seen his parents indicate the same feelings, he will learn to do this.
6. When the child does something that he knows he should not do, he may attempt to deny having done anything wrong. He also may begin to show guilt feelings for having misbehaved. Guilt is an important feeling for the child to develop; however, there should be a balance between feeling guilty too much of the time over minor problems or accidents and not feeling guilty at all.

INDICATIONS OF DIABILITY:

If the child develops or expresses only negative emotions, further counseling is advisable. If he feels too guilty over minor infractions or does not feel guilty at all over any of his behavior by his sixth year, he will require additional counseling.

MATERIALS:

A pet, if possible

INITIAL RESPONSE FORM

NAME_____ BIRTHDATE_____

TEACHER_____ DATES ASSESSED

CLASS OR SETTING_____ 1st_____
day month year

ADDRESS_____ 2nd_____
day month year

_____ 3rd_____
day month year

_____ 4th_____
day month year

COMMENTS

Fine Motor
(orange)

1FM03W	(Y)	N	?	Grasp Reflex Predominates
10FM1-2	(Y)	N	?	Hands May Be Open (at Six Weeks)
13FM2	(Y)	N	?	Eyes Follow Dangling Toy or Lighted Object
16FM2	(Y)	N	?	Manipulates Object
20FM3	(Y)	N	?	Hands Held Loosely Open
29FM3	(Y)	N	?	Arms Activate When Child Sees Toy, Cup, Light, or Dangling Object
35FM4	(Y)	N	?	Plays Using Hands and Feet
38FM5	(Y)	N	?	Bangs Fist or Object in Play
47FM5	(Y)	N	?	Rotation of Wrist Present
48FM5	(Y)	N	?	Searches for Fallen Object
49FM6	(Y)	N	?	Holds Object Between Palm and Fingers--Ulnar-Palmar Grasp
54FM7	(Y)	N	?	Holds Object with Side of Palm and Thumb--Radial-Palmar Grasp (Between Thumb and Index Finger)
56FM7	(Y)	N	?	Uses Either Hand
65FM8	(Y)	N	?	Shakes Bell
66FM9	(Y)	N	?	Grasps Object Between Thumb and the First and Second Fingers--Radial-Digital Grasp
79FM12	(Y)	N	?	Bangs Two Cubes--at Least Three Times
80FM12	(Y)	N	?	Pulls Pegs One by One from Pegboard
87FM12	(Y)	N	?	Pushes Car
91FM12	(Y)	N	?	Makes Little Spatial Error in Reaching
92FM12	(Y)	N	?	Removes Small Object from Bottle
103FM18	Y	(N)	?	Marks with Pencil Rather than Writes
104FM18	(Y)	N	?	Places Pegs in Pegboard and Takes Them out
110FM24	Y	N	?	Turns Nut off Bolt
111FM24	Y	N	?	Pulls String from a Pulley Twelve Inches or More
112FM24	Y	N	?	Fills and Dumps Containers with Sand
117FM24	Y	N	?	Builds Tower of Six or Seven Cubes
122FM30	Y	N	?	Holds Crayon in Fingers
130FM36	Y	N	?	Pushes Toy on a Ten-Foot Line
133FM36	Y	N	?	Manipulates Egg Beater
141FM48	Y	N	?	Places Round and Square Pegs in Holes
143FM48	Y	N	?	Places Coins in a Bank
148FM60-72	Y	N	?	Cuts Straight Line with Scissors at Least Four Inches
154FM72	Y	N	?	Pounds Nail in Board
155FM72	Y	N	?	Uses Screwdriver
159FM72	Y	N	?	Builds Creative Structures with Blocks

Self Help
(green)

1SH0-3W	(Y)	N	?	Mouth Opens for Nipple
6SH5	(Y)	N	?	Supports Bottle by Self
13SH12	(Y)	N	?	Pulls Off Socks
14SH12-18	(Y)	N	?	Spoon-Feeds Self
16SH15-18	Y	N	?	Indicates Wet Pants or Puddles
18SH15-18	Y	N	?	Awakes Dry from Nap
21SH18	Y	N	?	Wants Mother to Stay Near Bed
25SH18-24	Y	N	?	Walks Outside
31SH21	Y	N	?	May Awake for Toileting
39SH24	Y	N	?	Unties Shoes
44SH24	Y	N	?	Takes Toys to Bed
47SH24	Y	N	?	Dries Hands and Face Randomly
50SH24	Y	N	?	Moves About Yard
51SH24	Y	N	?	Unwraps Candy or Finger Foods
59SH30	Y	N	?	Periods Between Eliminations Extend to at Least Two Hours
79SH36	Y	N	?	Unties and Unlaces Shoes
82SH36	Y	N	?	Less Dependent on Toys
88SH36-48	Y	N	?	Dries Hands and Face
89SH36-48	Y	N	?	Gets Drink of Water by Self
91SH36-48	Y	N	?	Moves Chair If Needed
95SH36-48	Y	N	?	Attempts to Wipe Self
109SH48	Y	N	?	Unbuttons Shirts with Medium-Sized Buttons
111SH48	Y	N	?	Puts Off Going to Bed
117SH48	Y	N	?	Drains Bathtub
127SH48-72	Y	N	?	Peels Banana
130SH48-72	Y	N	?	Snaps Pants
134SH48-72	Y	N	?	Opens and Closes Car Door
137SH60	Y	N	?	Pours from Large Pitcher
138SH60	Y	N	?	Does Not Tell When Going to Toilet
140SH60	Y	N	?	Quieter During His Sleep
149SH60	Y	N	?	Begins Showering
154SH60	Y	N	?	Undresses Independently
162SH72	Y	N	?	Pulls On Rubber Boots
169SH72	Y	N	?	Pours from Thermos
172SH72	Y	N	?	Showers Self
173SH72	Y	N	?	Goes to the Store and Spends Money

Intellectual Development
(blue)

1ID1	(Y)	N	?	Follows Object Through 180° Arc
3ID2	(Y)	N	?	Becomes Concerned with Hands
4ID2	(Y)	N	?	Focuses on Two Objects Alternately
5ID2-3	(Y)	N	?	Explores Space with Arms and Legs
12ID4	(Y)	N	?	Uses Specific Action as "Procedure," an Act Interpreted as Causing Another Action
23ID8	(Y)	N	?	Uses Locomotion as Means
24ID8-12	(Y)	N	?	Crawls Through Tube
26ID9	(Y)	N	?	Uses Container to Hold Object
29ID11-13	(Y)	N	?	Finds Object Under Three Superimposed Coverings
30ID12	(Y)	N	?	Plays Peek-A-Boo
32ID12-15	(Y)	N	?	Requests Mechanical Toy to Be Started Again
41ID16-18	(Y)	N	?	Makes Detours
43ID18	Y	N	?	Places Small Kitchen Canister in Large Canister
44ID18	(Y)	N	?	Points to Eyes, Ears, Nose, and Mouth
46ID18-24	(Y)	N	?	Indicates Absence of Familiar Persons
49ID18-36	Y	N	?	Nests Four Kitchen Canisters
54ID22-24	Y	N	?	Develops Foresight in Problem of the Solid Ring
55ID24	Y	N	?	Points to Hands, Feet, Fingers, Toes
59ID24-36	Y	N	?	Identifies Hard and Soft
60ID30	Y	N	?	Repeats Two Digits One of Three Trials
63ID36-42	Y	N	?	Determines the Same and Not the Same in Number of Objects
69ID36-72	Y	N	?	Identifies Place by Sounds
72ID42-48	Y	N	?	Makes Gross Measurements Using Ruler
79ID48-54	Y	N	?	Repeats Four Digits One of Three Trials
80ID48-54	Y	N	?	Learns Concepts of Yesterday, Today, Tomorrow
83ID48-60	Y	N	?	Uses Terms "Left" and "Right," But Not Consistently
86ID48-60	Y	N	?	Arranges Items of Similar Shape by Size
89ID48-60	Y	N	?	Counts to Five
91ID48-60	Y	N	?	Predicts Weight of Objects
95ID48-72	Y	N	?	Sorts Basic Geometric Shapes
99ID48-72	Y	N	?	Molds Clay
121ID60-72	Y	N	?	Shows Awareness of Body Image
122ID60-72	Y	N	?	Observes Size Differences in People
130ID60-72	Y	N	?	Arranges Ten Number Rods by Size
135ID72	Y	N	?	Arranges Objects by Direction
137ID72	Y	N	?	Locates Substance by Smell
139ID72	Y	N	?	Distinguishes Between Classes and Subclasses
140ID72	Y	N	?	Begins Using Clock to Tell Time

Language Development
(yellow)

1LD03W	(Y)	N	?	Birth Cry
14LD6-8	(Y)	N	?	Imitates Own Sounds--Babbling
22LD8-10	(Y)	N	?	Responds to Name
27LD9-12	(Y)	N	?	Responds to Words and Gestures
28LD12-14	(Y)	N	?	First Words
29LD12-18	Y	(N)	?	Names Objects
31LD12-24	Y	(N)	?	Names Actions
32LD12-48	Y	(N)	?	Uses Long "A" Sound
42LD12-48	Y	(N)	?	Uses "U" Sound (As in "Pull")
43LD14-18	Y	(N)	?	Uses Mostly Nouns
45LD16-24	(Y)	N	?	Identifies Nouns
50LD24-36	Y	N	?	Relates Simple Experiences
52LD24-36	Y	N	?	Uses Three-Word Phrases and Sentences
57LD24-42	Y	N	?	Uses "W" Sound
59LD24-72	Y	N	?	Listens to and Sings Songs
65LD24-72	Y	N	?	Names Common Animals
72LD24-72	Y	N	?	Names People by Occupation
73LD24-72	Y	N	?	Describes by Feel
79LD24-72	Y	N	?	Describes Objects by Visual Appearance
82LD30-72	Y	N	?	Uses Adjectives
88LD36-48	Y	N	?	Uses "I" in Sentences
101LD36-48	Y	N	?	Uses Correct Subject-Verb Formation
105LD36-54	Y	N	?	Uses "D" Sound
108LD36-54	Y	N	?	Uses "G" Sound
110LD36-72	Y	N	?	Listens to Stories
124LD42-48	Y	N	?	Uses "To" in an Infinitive
129LD48-60	Y	N	?	Uses "This" and "That" or "These" and "Those"
130LD48-72	Y	N	?	Generates Novel Utterances
134LD48-72	Y	N	?	Retells Stories
136LD60-72	Y	N	?	Uses "V" Sound
142LD60-72	Y	N	?	Uses "Th" Sound (As in "Them")
145LD60-72	Y	N	?	Describes Outing
147LD66-72	Y	N	?	Uses "J" Sound
150LD72	Y	N	?	Has Good Use of Language

Physical Development
(pink)

1PD03W	(Y)	N	?	Prone Placement-Head Rotates
2PD03W	(Y)	N	?	Sitting-Head Sags, Uniformly Rounded Back
4PD03W	(Y)	N	?	Makes Alternating Leg Crawling Movements
6PD1	(Y)	N	?	Hands Form Fists
7PD1	(Y)	N	?	Leg Thrusts in Play
18PD3	(Y)	N	?	Rolls From Side to Back
22PD3	(Y)	N	?	Sits Supported-Slight Head Lag
24PD3	(Y)	N	?	Standing Supported-Bears Small Fraction of Weight
26PD4	(Y)	N	?	Holds Head Steady
43PD6	(Y)	N	?	Sits Alone-Engages in Other Activities
47PD6-10	(Y)	N	?	Scoots Along Floor
48PD6	(Y)	N	?	Standing Position-Bears Large Fraction of Weight on Legs While Supported
51PD7-9	(Y)	N	?	Moves About by Rolling
53PD7-8	(Y)	N	?	Lifts Head and Shoulders in Supine Position
66PD10-11	(Y)	N	?	Stands Alone Momentarily
67PD10-11	(Y)	N	?	Walks When Led
69PD10-18	(Y)	N	?	Sitting-Pivots Around on Buttocks
71PD10-17	(Y)	N	?	Rolls Ball Forward
72PD10-17	(Y)	N	?	Creeps on Hands and Feet
77PD14-17	(Y)	N	?	Climbs Stairs on Hands and Knees
82PD14-17	(Y)	N	?	Creeping Discarded
87PD18	(Y)	N	?	Walking-No Longer Walks with Wide Base of High-Stepping Gait
91PD18	(Y)	N	?	Climbs into Adult Chair
93PD18	(Y)	N	?	Picks Up Object From a Standing Position and Flings It
98PD19-24	Y	N	?	Squats to Pick Up Objects
99PD19-24	Y	N	?	Runs Flat Footed
100PD19-24	Y	N	?	Kicks Large Ball on the Ground
102PD19-24	Y	N	?	Jumps off Twelve-Inch Box Alone-One Foot Ahead, Step Jump
104PD19-24	Y	N	?	Ascends Four Steps Seven Inches High-Marks Time Unsupported
106PD19-24	Y	N	?	Walks with One Foot on Walking Board
107PD19-24	(Y)	N	?	Stands Up-Turns to Side First
108PD19-24	Y	N	?	Rides Three-Wheeled Kiddie Car or Tricycle a Short Distance
121PD31-36	Y	N	?	Catches Large Six-Inch Ball-Arms out Straight

Physical Development (cont'd)
(pink)

124PD31-36	Y	N	?	Walks a One-Inch by Ten-Foot Straight Line-Three Steps Off
133PD31-36	Y	N	?	Jumps Over String-Two Inches High
135PD31-36	Y	N	?	Balances on One Foot-Unsupported for Five Seconds
138PD31-36	Y	N	?	Descends Eleven Steps-Marks Time Unsupported
146PD37-42	Y	N	?	Gallops or Half-Skips
155PD43-48	Y	N	?	Hops on One Foot-Four to Six Times
157PD43-48	Y	N	?	Ascends Large Ladder, Twelve Inches Between Rungs-Alternates Feet with Ease
164PD55-60	Y	N	?	Throws Small Three-Inch Ball-Distance of Thirteen Feet
165PD55-60	Y	N	?	Hops on One Foot-Seven Times
166PD55-60	Y	N	?	Skips-Alternates Feet Fair to Good
167PD55-60	Y	N	?	Walks Well-Swings Arms and Legs Freely
168PD55-60	Y	N	?	Stands on One Foot-Ten Seconds
169PD55-60	Y	N	?	Descends Large Ladder Twelve Inches Between Rungs-Alternates Feet with Caution
173PD60-72	Y	N	?	Bounces Large Six-Inch Ball with Both Hands-Distance of Seven Feet

Social Personal
(white)

1SP0-1	(Y)	N	?	Quiets When Picked Up
4SP1	(Y)	N	?	Exhibits Anticipatory Excitement
8SP4	(Y)	N	?	Engages in Exploitive Play
13SP6	(Y)	N	?	Laughs Aloud
18SP12	(Y)	N	?	Responds to Voice and Facial Expressions
19SP12	(Y)	N	?	Amuses Self
26SP18	(Y)	N	?	Carries Doll
32SP18	(Y)	N	?	Waves "Bye-Bye"
43SP24	Y	N	?	Plays Games with Adult
44SP24	Y	N	?	Identifies Own Possessions
53SP36	Y	N	?	Takes Turn
54SP36	Y	N	?	Puts Away Toys
60SP36	Y	N	?	Shows Signs of Emotion
71SP48	Y	N	?	Likes to "Dress Up"
73SP48	Y	N	?	Attends to Task
83SP60	Y	N	?	Attends Within Large Group
85SP60-72	Y	N	?	Finishes Projects
95SP72	Y	N	?	Continues Dramatic Play from Day to Day
96SP72	Y	N	?	Cooperates with Companions

SAMPLE PROFILE CHART SHOWING EX

Date of Assessment		DEVELOPMENTAL AGE	0-1 month	2-4 months	5
	FINE MOTOR	HAND USE	1 2 3 4 8	10 11 14 19 20 22 30	36 41 4
		VISUAL MOTOR	5 6 7 9	12 13 15 18 23 24 27 29 31 32 34	42
		OBJECT MANIPULATION		16 17 21 25 26 28 33 35	37 39
		POUNDING			
		WRIST ROTATION			
		FINGER USE			54
	INTELLECTUAL DEVELOPMENT	OBJECT PERMANENCE	1	2	13
		ENVIRONMENTAL EVENTS		3 6 7 11	
		OBJECT IN SPACE		4	8
		SELF IN SPACE		5 9	1
		OPERATIONAL CAUSALITY		12	15
		SENSORY DISCRIMINATION			
		SERIATION			
		BODY IMAGE			
	LANG DEVELOP.	PRE-VERBAL BEHAVIOR			
		SPONTANEOUS SPEECH			
		VOCABULARY			
		SENTENCE STRUCTURE			
	PHYSICAL DEVELOPMENT	HEAD CONTROL	1	27 28 29	36
		SITTING	2 11	15 17 19 22 32 34	35 37
		CREEPING, CRAWLING	4	13 30 31	39
		ARM CONTROL	5 6	16	
		WALKING	7	23	
		ROLLING		18 20	40
		STANDING		24 33	4
		CLIMBING			
		KICKING			
		RUNNING			
		JUMPING			
	SELF-HELP	EATING	1 2 3	4 5	6
		DRESSING			
		SLEEPING			
		TOILETING			
		MOBILITY			
		GROOMING			
	SOC. PER.	PLAY		8 10	11
		SOCIAL INTERACTION	1 2 3 4	5 6 7 9	13
		BEHAVIORAL ADJUSTMENT			97

AMPLES REFERRED TO IN INSTRUCTIONS

- 8 months	9 - 12 months	13 - 18 months	19 - 24 months
95 50 51 53 55 56 57 59 8	87	97 99	111 118
3 48 62 63	67 71 74 78 84 91	94 95 98 100 101 103	106 107 108 114 115 116 117
40 44 45 46 52 58 65	75 76 77 82 88 89 92	93 96 102	112
38	69 72 79		119
47			110
61 64	66 68 70 73 80 81 83 85 86 90	104 105	109 113
19 21 22	27 29	33 35 36 42	46 52 56
23	28 31	34 39	51 54
14 20	25 26	37 38 40 41	
0 17	24		50
16 18		32	53
30			
			43 47 48 49
			44 45 55
	27		
		28 30 43	47
		29	31 44
			45 46
41 53			
38 42 43 49 52	58 61 63 65	69	
44 46 47	55 57 60 68	70 72 80 82	
		71 76 85 93 94	96 97 98
	62 64 67	74 75 79 81 83 84 87 89 90	95 106
45 50 51			
54	56 59 66	73 78	107
		77 86 88 91	103 104
		92	100
			99 105
			101 102
7 8	9	14	27 40 41 42 51
	10 11 12 13	If this is the highest item the child can complete, check this item →	32 33 34 35 36 37 38 39
		15	19 21 30 43 44
		16 17 18	20 22 26 28 29 31 52
		23	24 25 48 49 50
			45 46 47
12 14	19	20 21 22 23 26 28 30 31	35 36 38 43
15 16	17 18	24 25 27 29 32	33 34 37 39 40 41 42 44 45
98 99 100	101 102 103 104	105 106 107 108	109 110 111 112 113

INSTRUMENTS	SCORES AND DATES
Vision	
Barraga Visual Efficiency Scale	
Developmental Test of Visual Motor Integration	
Frostig Development Test of Visual Perception	
Auditory	
Goldman-Fristoe-Woodcock Test of Auditory Discrimination	
Wepman Test of Auditory Discrimination	
Motor	
Lincoln-Oseretsky Test of Motor Development	
Peabody Scale of Motor Development	
Language	
A Preferred Articulation Test	
I.T.P.A.	
Peabody Picture Vocabulary Test	
Utah Test of Language Development	
Intelligence	
Slosson	
Stanford-Binet	
W.I.S.C.	
Developmental	
Bayley Scales	
Denver Developmental Screening Test	
Gesell Scales	
Vineland Social Maturity Scale	
Maxfield-Buchholz	
Behavior	
A.A.M.D. Adaptive Behavior Scales	

PROFILE SHEET

Name _____ Sex _____ Birthdate _____

Instructor's Name _____

Address _____ (agency)

_____ (street)

_____ (city) (state) (zip)

TYPE OF PROGRAM

_____ Day School _____ Residential

_____ Homebound _____ Other

This child has been seen by the following specialists:

	Address	Date Examined
Optometrist		
Ophthalmologist		
Otologist		
Audiologist		
Occupational Therapist		
Physical Therapist		
Speech Therapist		
Psychologist		
Social Worker		
Special Education Teacher (Resource Room, Clinic, Itinerant, Homebound)		

IMPAIRMENTS IDENTIFIED

Vision:	L	20/70	20/200	CF	LP
	R	20/70	20/200	CF	LP
		Mild	**Moderate**	**Severe**	**Profound**
Auditory:	L	_____	_____	_____	_____
	R	_____	_____	_____	_____
Motor:	L	_____	_____	_____	_____
	R	_____	_____	_____	_____
Intellectual:		_____	_____	_____	_____
Other: (describe)		_____	_____	_____	_____

DATA COLLECTION SHEET

STUDENT: Cindy

CARD NUMBER: 36PD5

0 = Unsuccessful

+ = Successful

P = Participates

DATE																							
2-21	0	0	0	0	0	0	0	0	0	0	0	0											
2-22	0	0	0	0	0	0	0	0	0	0													
2-24	0	0	0	0	0	0	0	0	0	0													
2-25	0	0	0	0	+	0	0	0	+														
2-26	0	0	+	0	0	0	+	0	0														
2-27	0	0	0	+	+	0	0	0	0	0													
2-28	0	0	+	+	+	+	0	0	0	0													
3-1	0	0	0	0	0	0	+	+	0	0													
3-2	0	+	+	+	0	+	+	0	0														
3-3	+	+	+	+	0	+	+	+															
3-4	+	+	+	+	+	+		Teacher Test															

103

119

120

SELF-HELP

AREA: Eating

1SH0-3W	The child is able to open his mouth spontaneously and with stimulation to receive the nipple of either a bottle or his mother's breast.
2SH0-3W	The child is able to suck milk from a bottle or his mother's breast to feed himself.
3SH1	When the child either sees or feels the nipple near his mouth, he will make searching movements to receive it.
4SH3	When the bottle enters the child's perceptual field -- where he can see or touch it -- he will reach for the bottle. (If the child is being nursed by his mother, he will reach out to her in a nursing situation.)
5SH3	The child is able to eat baby foods if someone else feeds them to him.
6SH5	The child holds a bottle by himself while he is drinking from it.
7SH8	With assistance, the child is able to drink small amounts of liquid from a cup.
8SH8	The child is able to chew soft foods and swallow them if they are put in his mouth.
9SH8-12	The child finger-feeds himself hard substances, such as meat, corn, beans, breads, cookies, fruit, etc.
14SH12-18	The child spoon-feeds himself by grasping the spoon with his fist and scooping food to his mouth without turning the spoon in his mouth, e.g., mashed potatoes, cereal, pudding, noodles, and other soft foods.
27SH18-24	The child fork-feeds himself by grasping fork with fist and scooping food to his mouth, e.g., beans, potatoes, corn, etc.
40SH24	The child is able to grasp a glass or cup with both hands with thumbs in opposition; then he is able to drink.
41SH24	The child is able to suck liquid through a plastic straw.
42SH24	The child is able with an overhand grasp to use a spoon, scooping food independently without spilling.
51SH24	The child is able to unwrap pieces of candy or finger foods by himself before he eats them.
64SH30-60	The child enters mealtime conversations and as part of the conversation requests specific foods.

NUMERICAL INDEX

SELF-HELP

CARD NO.	TITLE
1SHO-3W	Mouth Opens for Nipple
2SHO-3W	Sucks from Nipple
3SH1	Active Search for Nipple
4SH3	Reaches for Bottle
5SH3	Eats Baby Food
6SH5	Supports Bottle by Self
7SH8	Drinks from Cup
8SH8	Eats Soft Foods
9SH8-12	Eats Finger Food
10SH11	Holds Out Arms and Legs for Dressing
11SH12	Assists in Putting Arms in Sleeves and Legs in Pants When Being Dressed
12SH12	Pulls Off Shoes
13SH12	Pulls Off Socks
14SH12-18	Spoon-Feeds Self
15SH15	Put to Bed Easily
16SH15-18	Indicates Wet Pants or Puddles
17SH15-18	Cooperative Toilet Response
18SH15-18	Awakes Dry from Nap
19SH15-36	Naps Once a Day
20SH18	Awakes and Cries to Be Changed
21SH18	Wants Mother to Stay Near Bed
22SH18	Awakes Crying
23SH18	Seats Self in Chair
24SH18-24	Walks About Small Room
25SH18-24	Walks Outside
26SH18-24	Toilet Regulated
27SH18-24	Fork-Feeds Self
28SH21	Tells Need of Toileting
29SH21	Increases Frequency of Urinating
30SH21	Doesn't Go to Sleep at Once
31SH21	May Awake for Toileting
32SH24	Pulls Off Gloves or Mittens
33SH24	Can Put Toes in Shoes
34SH24	Pulls Shoes over Heel
35SH24	Pulls Socks On
36SH24	Pulls Off Underpants
37SH24	Takes Off Pants
38SH24	Puts On Hat
39SH24	Unties Shoes
40SH24	Holds Cup with Both Hands and Drinks
41SH24	Uses Straw
42SH24	Spoons with Overhand Grasp
43SH24	Can Be Wakened Without Fussing

SUGGESTED INSTRUCTIONAL MATERIALS

LIGHT SOURCES	TACTILE STIMULUS	SOUND SOURCES	CLOTHING ARTICLES	KITCHEN ARTICLES
flashlight with red lens cover	hand-held hair dryer	bells	scarves	hard candy
photo flash system	sweet sticky syrup	wrist bells	old zipper	fruit jar rings
lighted rattle	finger paints	rattle	coat hanger	large spoon
pen light	feathers	musical mobile	shoestring	child's cup
Christmas lights	pieces of cloth	drum	socks	cereal
patio lights	paper from magazine	whistle	buttoning frame	small finger foods
luau lights	unprinted newsprint	music box	mitten	small sponge
	velvet upholstery fabric	oscillator	small blanket	shallow bowl
	yarn balls	"cricket"	shirt or blouse	cutting board
	nerf balls	high-pitched bell	dressing frame	cookie sheet
	dust brushes	transistor radio	buttons	egg carton
	stuffed animals	television	lacing board	butcher's paper
	upholstery fabric	tape recorder	shirt jacket	plastic bottles (different sizes)
	textured ball	record player	slip-on shoes	chocolate pudding
	feather duster	beep ball	elastic waisted pants	jars with lids
	paintbrushes	rhythm band instrument	child's coat	mixing bowl
	ice cubes		child's sweater	egg beater
			formboard with zipper	round colored tooth-picks
			formboard with snaps	plastic dinner plate
			pullover shirt	match sticks
			jeans with belt loop	milk
			clothes rod	baby bottle
			clothes closet	paper cup
			rubber overshoe	plastic straw
			old clothes	plastic lid
			costumes	tray or plate with compartments
				plastic pitcher (top)

APPENDIX II: PARENT NEEDS INVENTORY

PART ONE: INTRODUCTION

A. STATEMENT OF NEED

A current trend in programs serving handicapped children is homebased intervention. These programs work with parents in the home and assume that since the parents know the child best they are most capable of meeting the child's needs. Professionals in these programs teach the parents how to teach their children within the context of normal child development. Although home-based intervention programs are proving to be successful, two difficulties have been identified.

One difficulty is that often the attitudes and concerns of the parent are overlooked or simply not considered because most of the professional's attention is given to the child. Kennell and Klaus (1975) and Brazelton et. al (1975) have shown that the infant-parent relationship is reciprocal rather than unilateral--that the infant affects the parent development just as the parent affects the child's development. Another difficulty lies in the lack of an objective instrument to measure the effectiveness of the home-based program that attempts to deal with parents needs and attitudes.

The Parent Needs Inventory (Experimental Edition 1979) is designed to help alleviate these difficulties. It enables the professional to work with the parent to determine "Target Items" --specific areas of concern for the parents. By isolating "Target Items", the professional knows where to begin work with the parent and which concerns have highest priority. By identifying "Target Items" several times during the year, the parent and professional can determine the amount of change in any given need or concern. By examining these changes, the professional and the parent can measure the effectiveness of the home-based intervention program.

B. AREAS OF CONCERN:

In order for a parent to successfully interact with his handicapped child, he must deal with his feelings toward the child and the handicap. The parent needs an understanding of the basic principles of child development so he can set reasonable expectations for the child, understand the assessment of the child, and understand the educational goals written by educators. In order for the family to successfully interact with the community, the parent needs an awareness of, and ability to use local resources such as financial aid, counseling services, and recreational opportunities. The three sections of the PNI reflect the parent's

feelings in these areas - the grieving process, knowledge of child development and knowledge of local resources.

Each of the three areas is divided into categories which consist of three or four statements of feeling about a situation. There are twenty-five statements in each area. Statements are based upon comments made by parents of handicapped children or were written by parents.

1. The Grieving Process.

The Grieving Process can be thought of as a collection of reactions to the birth of a handicapped child. The stages of the Grieving Process are denial, anger, guilt, depression, bargaining, and acceptance. These stages are not necessarily sequential, nor does arrival at the acceptance stage signify a permanent acceptance of the situation. Also, one of the parents might be in a particular stage while the other parent is in a different stage.

A parent in the denial stage refuses to accept the existence of the handicapping condition or the effect it has on the child. This parent may agree that the condition exists, but insists that the child will outgrow the condition. (Cards #19, 21)

Parents in the anger stage feel that having a handicapped child is an unjust and unfair situation. The parent's anger may be directed toward the spouse or other family members even though the anger is related to the handicapped child. (Cards # 4,15,16,23, 24,25)

Parents experiencing the guilt stage feel that they are responsible for their child's condition. Their guilt may be based on a real or imagined lapse in their moral, nutritional or medical care prior to the child's birth. (Cards#2,7,10,20)

Parents in the depression stage are overwhelmed by their situation and may be unable to function as members of the family or community. (Cards #1,11,17,18,22)

Parents in the bargaining stage have an unrealistic desire to remediate their situation. They appeal to a higher authority such as God to trade themselves for cure of their child. (Cards # 3,8, 14)

The acceptance stage occurs when the parents accept the child's strengths and needs and try to deal with the child at the child's level. Acceptance is not necessarily permanent; the parent may revert to other stages in the grieving process at later stages in the child's development such as adolescence or adulthood. (Cards #5,6,9,12,13)

2. Knowledge of Child Development.

Parents of handicapped children have a need to know how their child compares to other children the same age. This section of the assessment is used to pinpoint the parents' concerns regarding normal child development and helps the parent understand the child's assessment and educational goals.

Emotional Development refers to the child's moods and feelings. For example, it is helpful for parents to know that a six month old child may cry for an hour at the end of his day, but that this is not normal for a two year old. (Cards #3,11,19,21,25)

Intellectual Development refers to a child's ability to understand his environment. A child may be able to identify his ears, nose, mouth and eyes at eighteen months but is not aware of total body image until age five. Parents need to know what the child should be learning at each age. (Cards #2,10,17,18.20)

Behavioral Development refers to the way a child interacts with others. An infant fusses to bring a parent closer; a three year old is able to ask for attention. It is helpful for a parent to know which is appropriate behavior. (Cards #4,5,6,24)

Physical Development refers to a child's ability to use his body. A child may be able to stand at ten months, but is not expected to kick a ball until nineteen months. (Cards #7,14, 15,22)

The Medical area examines the relationship between health and child development. For example, a child who is on seizure medications may tend to be lethargic and may experience developmental delays due to the lethargy; this is important for parents to know. (Cards #1,8,9,12,13,16,23)

3. Knowledge of Local Resources.

Knowledge of local resources helps the parents meet the needs of the handicapped child and the family. Here the focus is on the family's awareness of, and ability to use their local support services.

Educational Services refers to instruction for the parents which may include dealing with their children, furthering their own formal education, or participating in special interest classes, such as tennis, pottery, or bird watching. (Cards #9,11,16,17,19,20)

Financial Services refers to needs of the child, such as medical expenses, and the needs of the family, such as rent payments. (Cards #3,4,13,22)

Counseling Services includes professional, psychological, genetic, or rehabilitative guidance for the parent, the child, the siblings, or the entire family. (Cards #14,21,23,24,25)

Recreational Services refers to having fun. Parents may need information about programs that include handicapped children and activities their children might enjoy. Also, the parents may need help arranging babysitting or respite care so they may have recreation time. (Cards #2,7,8,12,15)

Legal Services refers primarily to laws regarding the handicapped, such as Public Law 94-142 (Education of Handicapped Children). Also, the family may have legal concerns such as racial discrimination or consumer protection. (Cards #1,5,6,10,18)

C. "REAL" SELF AND "IDEAL" SELF

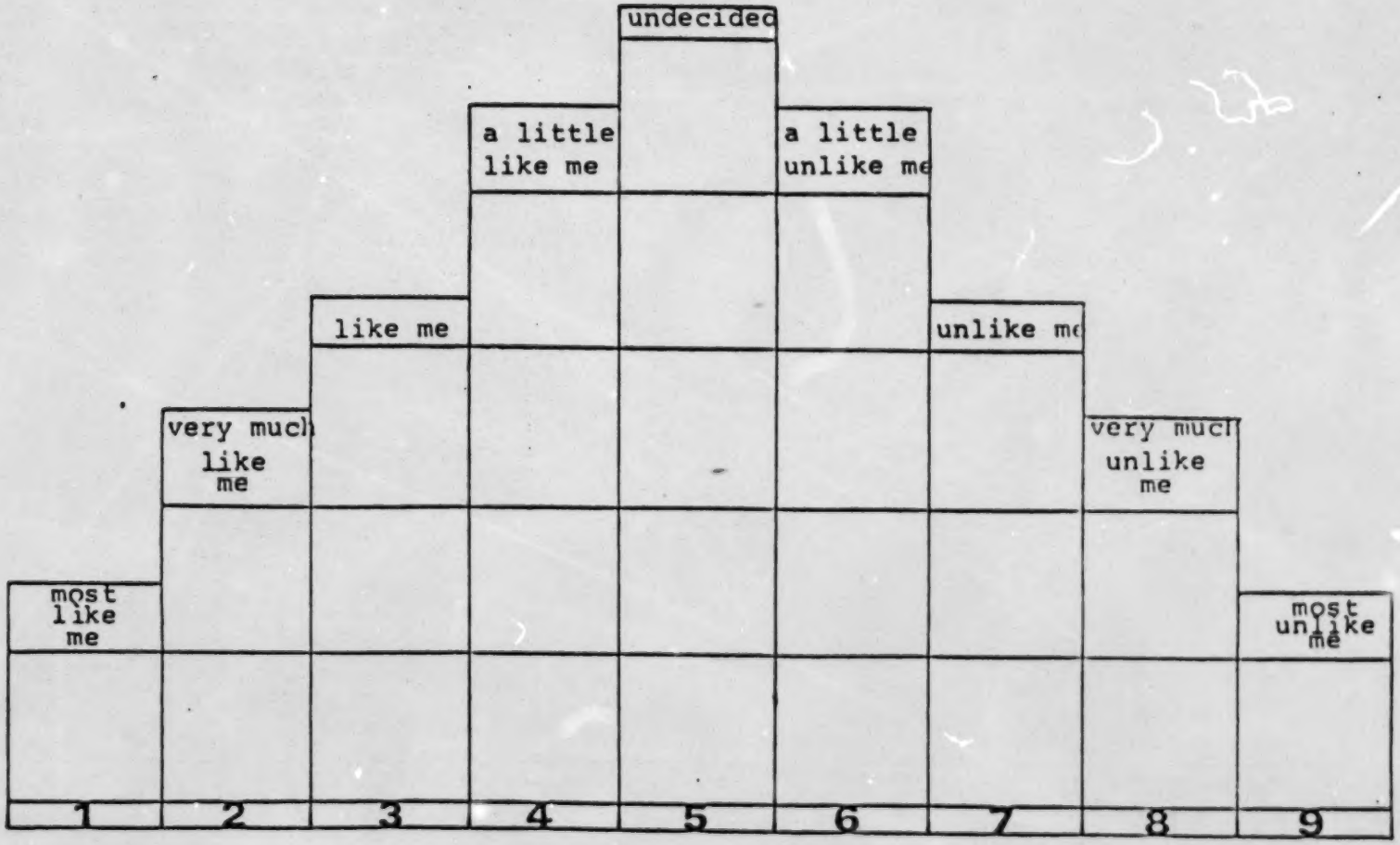
The Parent Needs Inventory assumes that every person, including parents of handicapped children, has an "Ideal" self and a "Real" self. Each parent has an image of himself as he would like to be, if he could be the perfect parent (the "Ideal" self). He may have never verbalized this image, and no one is expected to live up this "Ideal" self, but it does exist.

The "Real" self is how he sees himself at this point in his life--his image of himself based on past experiences and on the feedback he receives from other people. The person's self-concept is the relationship between the "Real" and the "Ideal" selves.

D. THE Q-SORT

The Q-Sort, which was adapted from Kroth (1976) is the format used in the Parent Needs Inventory. The PNI Board displays a pyramid of twenty-five 2½" squares, arranged in columns numbered 1-9. Each column is labeled with a descriptor ("most like me", "very much like me", "like me", "a little like me", "undecided", "a little unlike me", "unlike me", "very much unlike me", "most unlike me"). (See the example on page 111.)

PARENT NEEDS INVENTORY



Also included with the Q-Sort materials are three sets of 2" x 2½" colored cards, representing the three areas of concern. Each set contains 25 cards each of which is printed with a statement.

To complete the PNI Q-Sort, the parent arranges the 25 cards of one set on the PNI Board, one card to a square depending on how he feels about the statement on the card. For example, if he feels that the statement is very much like him, he places the card on either of the two squares in the column "very much like me". The parent may rearrange the cards as often as necessary until he feels that the arrangement provides an accurate representation of his feelings.

The parent may find it difficult to choose between columns when placing the card on the PNI Board. The fact that <u>one</u> card must be chosen as "most like me" requires the parent to be very selective in arranging the cards. Although the procedure may seem difficult, it forces the parent to be deliberate in his arrangements, and is necessary to identify priorities.

This sorting process is performed for the "Real" self and the "Ideal" self with each of the three sets of cards. Therefore, each parent will complete the Q-Sort a total of six times.

Those statements which appear in significantly different positions between "Real" and "Ideal" Sorts indicate specific needs or attitudes which concern the parents. Also, the correlation of the placement of the statements between sorts is a measurement of self-concept in terms of a discrepancy between the parent's "Real" and "Ideal" selves. Comparing the correlations over a period of time indicates the degree of parental development or change.

<u>PART TWO: INSTRUCTIONS</u>

A. <u>WHERE AND WHEN, WHO AND HOW</u>

The PNI is designed to be administered in a relaxed environment such as the home. Although it provides a place to begin work with the parents, it should not be administered during the first visit. The initial meeting should be reserved for becoming acquainted and for building a feeling of trust that will allow the parent to feel comfortable with you.

Each of the three sections of the PNI requires about 60 minutes to complete, depending on the parent and the circumstances. It is not necessary to complete all three sections at one meeting, but the "Real" self Sort and the "Ideal" self Sort for a section

should be completed at the same time. If the parent has questions or comments, take time to listen and respond. Do not place a time limit on the parent or make him feel rushed.

The PNI should be administered to each parent individually. Not only does this allow more confidentiality, it eliminates the possibility of collaborating answers, thus providing a more accurate account of the individual's feelings. After both parents have completed a section of the PNI they can be given a chance to see and discuss each other's selections.

B. THE SORTING PROCESS:

Explain the PNI. Introduce the PNI to the parent by stating its purpose--to determine the parent's areas of greatest concern. Paraphrase the description of the PNI from Part I, using whatever terminology you think the parent will understand. Assure him that there are no right or wrong answers, that no one will pass judgment on his responses, and that no one else will see the results without his permission. The parent may feel more comfortable if he is told that these are not trick questions--that most parents with handicapped children experience these feelings at some time and to some degree.

Explain that everyone has an "Ideal" self (the way he would like to be if everything were perfect, the way he wants other people to think of him)- but the "Real" self is the way he is, even if it doesn't match up to the "Ideal" self. Since these selves are almost always different, the PNI is given twice.

Explain the sections and the sorting procedure. Explain the three sections to the parent and briefly describe the subdivisions. Let the parent choose the order in which he wants to complete the sections.

Complete the PNI for one section of the "Real" Self. Have the parent arrange the twenty-five statement cards on the PNI chart, rearranging the cards until they satisfactorily express his feelings about himself at this point in his life (or most of the time). It is usually easier for the parent to read each card and then place it on the board, than it is for him to read through all of the cards trying to find a statement to fit the column.

Record the results. Turn over each statement card on the PNI Board so that it remains in the position the parent placed it. The number on the back of the card will show. Using the Target Item Record Form (TIRF), record the numbers in each column. (There are three TIRF Forms--one for each of the three areas of

concern. The statements on the forms are abbreviated.)

For example, if Card 2 was sorted onto the "Most Like Me" column (column 1), mark a "1" (for column #1) under the "Real Sort" column next to number 2 (for card #2) in the "Card No." column on the TIRF. If cards number 1,14,15,19 and 24 are in the "undecided" column (column 5) write "5" under the "Real Sort" column next to the appropriate numbers. Study the example on the next two pages.

Let the parent record or watch you record the numbers. Although this may take more time, it will increase the parent's sense of participation.

Complete the PNI for the "Ideal self". Have the parent arrange the cards according to his "Ideal self", using the same instructions for the sorting procedure as for the "Real self". Reinforce the idea that we want the parent's personal ideal of himself, not society's expectations. Record the results under the column heading "Ideal Sort".

C. DETERMINING THE "TARGET ITEMS".

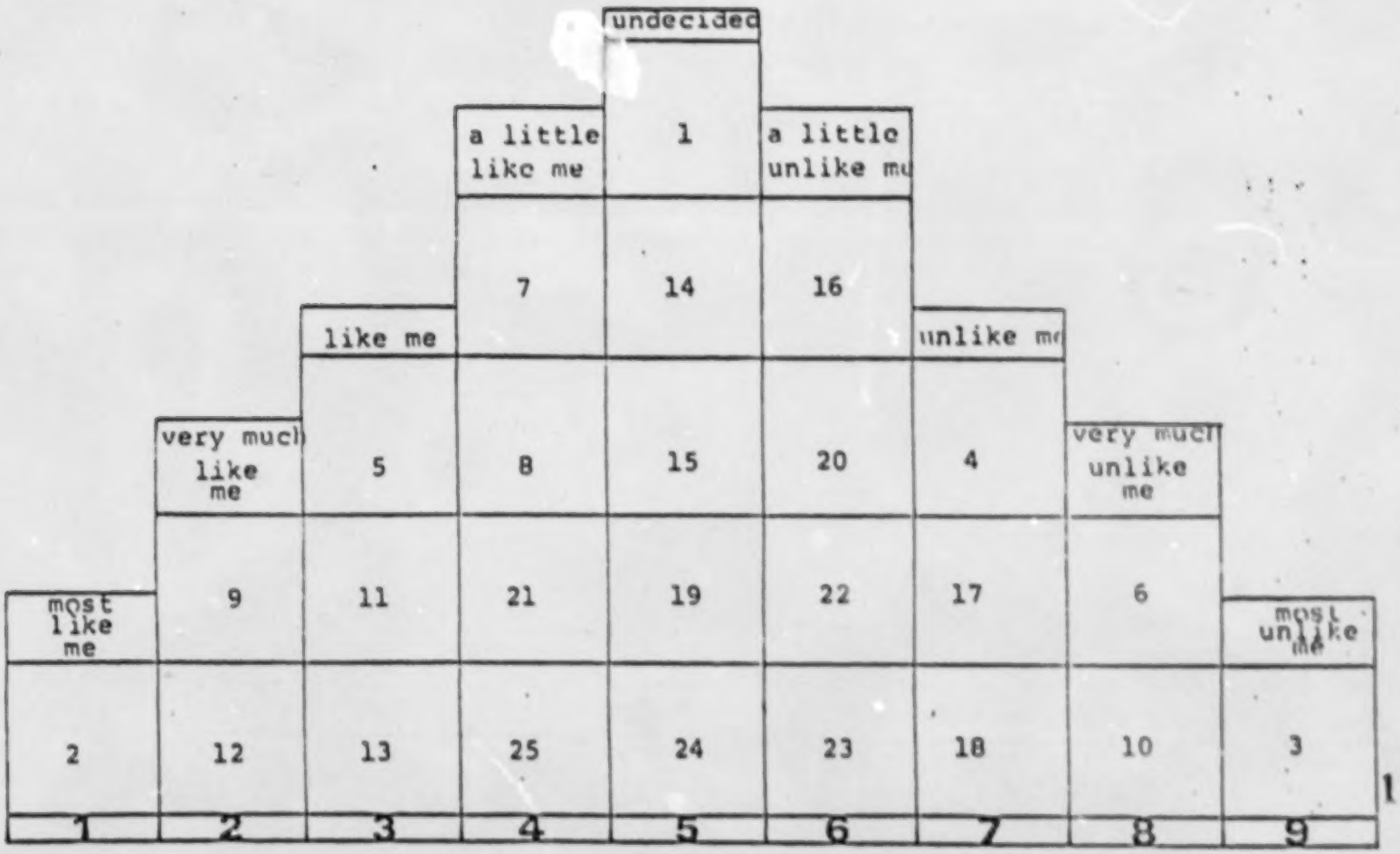
The statements which indicate the area of greatest need or concern are called "Target Items", The parent may wish to help with the calculations to determine the Target Items, or may simply want to watch you do it. In either case, complete the following calculations:

Find the numerical difference between the "Real Sort" and the "Ideal Sort" for each statement by subtracting the smaller column number from the larger column number. It does not matter whether the larger number was the "Real" or the "Ideal" Sort. Record the difference under the column heading "Difference".

For example:

Card No.:		Real:	Ideal:	Difference:
1.	I feel lost and alone in dealing with my child's problem.	9	1	8
2.	I feel that my child's handicap could have been prevented.	4	4	0
3.	I feel that there is a purpose for my child's handicap.	2	6	4

PARENT NEEDS INVENTORY



115

135

136

Do this for all 25 statements. Those statements with a difference of 4 or more are the Target Behaviors.

D. MEASURING SELF CONCEPT

The measure of self-concept is determined by figuring the correlation between the "Real" and the "Ideal" selves. The calculations used to determine the correlation may appear too complicated for some parents to complete. Other parents may feel more comfortable using a calculator to figure the correlation. Use your judgment to determine the best way to handle this situation.

a. Square the number in the "Difference" column for each statement, that is, multiply each number by itself. Write it in the column marked "Difference Squared".

b. Add all of the numbers in the "Difference Squared" column.

c. Divide the total by 200.

d. Subtract this number from 1.00.

This number (carried to 2 decimal places) is the correlation between the "Real" and "Ideal" Sorts. For example:

(a) Square the numbers)

	Statement:	Real:	Ideal:	Difference:	Difference Squared:
1.	I feel hurt when.....	6	2	4	16
2.	I take my child.....	5	5	0	0

(b) (Add the numbers in the "Squared" column) (16 + 0 = 16)
(c) (Divide by 200) 16 ÷ 200 = .08
(d) (Subtract the answer from 1) 1 - .08 = .92
.92 = correlation

Therefore, the parent has a self-concept of .92. Explain that this is a personal score and does not have a value or grade assigned to it. The closer the score is to 1.00 the closer the match between the "Real" and "Ideal" selves. A score of 1.00 is not expected, because that would mean there is a perfect match between the "Real" and "Ideal" selves.

E. INTERPRETING THE RESULTS

Discuss the results of each section with the parent before

completing the next section. Allow the parent to explore and discuss his feelings about each Target Item. The parent should be the one who does most of the talking. Your role in the discussion is not to tell him how he should be, but to provide guidance in his search to find answers.

Have the parent discuss and expand upon each Target Item by asking him questions such as, "Why do you think there is a difference between your "Real" and "Ideal" selves?; "Why do you think this is a more ideal way to feel?"; "What do you feel are the best ways to reach those ideal feelings?"

End by asking, "Do you have any questions about the process?" "Do you feel the results are valid?"

TARGET ITEMS RECORD FORM
(Grief)

Name of Child:_____ Sex:_____ Date Tested:_____
Address:_____ Phone:_____ Date of Birth:_____
School:_____ Teacher:_____ Grade:_____
Name of Parent: _____ Relationship to Child:_____

Card No.		Real Sort:	Ideal Sort:	Difference:	Difference Squared:
1	I feel lost and alone				
2	handicap could have been prevented				
3	purpose for handicap				
4	someone else is to blame				
5	I take my child anywhere				
6	there is a time to stop grieving				
7	something bad might happen				
8	I would change places with my child				
9	it is all right to show anger				
10	my child needs my help				
11	life is a burden				
12	I don't mind questions				
13	I feel proud of gains				
14	handicapped child causes stress				
15	more than my share of work				
16	normal don't have problems				
17	other children my child's age				
18	no one else is as hurt				
19	with my child in public				
20	behaved differently before				
21	there may be a cure				
22	I cry when I think				
23	I get angry more often				
24	supportive of my needs				
25	supportive of child's needs				

118

$$r = 1 - \left[\frac{\Sigma p^2}{200}\right]$$

$r =$_____

TARGET ITEMS
1
2
3
4
5

NOTE:
A Difference Squared of "16" or above, is a Target Item.

The Card Number will indicate the specific behaviors.

TARGET ITEMS RECORD FORM
(Local Resources)

Name of Child:_____ Sex:_____ Date Sorted:_____
Address:_____ Phone:_____ Date of Birth:_____
School:_____ Teacher:_____ Grade:_____
Name of Parent:_____ Relationship to Child:_____

Card No.		Real Sort:	Ideal Sort:	Difference:	Difference Squared:
1	I would sue				
2	need to get out				
3	help with medical bills				
4	help to buy things				
5	agencies treat me unfairly				
6	if I died				
7	not many fun things to do				
8	our family doesn't do				
9	go back to school				
10	agencies give run-a-round				
11	how to get services				
12	to get babysitter				
13	money problems cause trouble				
14	no one knows how I feel				
15	time away from kids				
16	take classes for job				
17	teach handicapped kids				
18	rights of handicapped				
19	classes for fun				
20	learn about handicapped				
21	trouble from having child				
22	helpless when can't pay bills				
23	hear my child cry				
24	punished by handicap				
25	blame me for handicap				

119

142

$$r = 1 - \left[\frac{\Sigma p^2}{200}\right]$$

141

r =_____

TARGET ITEMS
1
2
3
4
5

NOTE:
A Difference Squared of "16" or above, is a Target Item.

The Card Number will indicate the specific behaviors.

TARGET ITEMS RECORD FORM
(Child Development)

Name of Child:_____ Sex:_____ Date Sorted:_____
Address:_____ Phone:_____ Date of Birth:_____
School:_____ Teacher:_____ Grade:_____
Name of Parent:_____ Relationship to Child:_____

Card No.		Real Sort:	Ideal Sort:	Difference:	Difference Squared:
1	don't understand doctors				
2	child not ready for school				
3	feelings are different				
4	parents cause behavior				
5	children misbehave more				
6	punishment corrects behavior				
7	physical abilities different				
8	doctors should be understanding				
9	doesn't get along with children				
10	children should be learning				
11	child is unhappy a lot				
12	physical problems cured				
13	effects of medicines				
14	physical problems cause problems				
15	know about development				
16	health affects behavior				
17	learning as fast as others				
18	child is smart/slow				
19	understand child's feelings				
20	doing right to learn				
21	child can't control feelings				
22	child is physically different				
23	doctors give answers				
24	children act their age				
25	know how child feels				

$$r = 1 - \left[\frac{\Sigma d^2}{200}\right]$$

r =_____

TARGET ITEMS
1
2
3
4
5

NOTE:
A Difference Squared of "16" or above, is a Target Item.

The Card Number will indicate the specific behaviors.

APPENDIX III: READING AND RESOURCES FOR PARENTING

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National Association of Parents of Visually Impaired and Blind, Lee Robinson, co-ordinator, 1100 W. 45th St., Austin, Texas 78756.

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